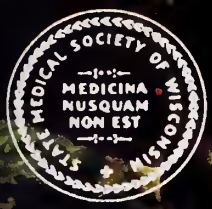

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Contents

January 1994 Vol. 93 No. 1

Opinions

3 *President's page*
Chicken soup
by Pauline M. Jackson, MD, La Crosse

4 *EVP report: The view from here*
Is anybody listening?
by Thomas L. Adams, CAE, Madison

6 *Letters*
Support for generalist track in medical school
by Norman Jensen, MD, Madison

7 Medicine ruled by the whims of tyranny
by James P. Fogarty, MD, Barron

Scientific

9 The outcome status of chronic pain patients 4 years after multidisciplinary care
by Timothy E. Tyre, PhD; Diane E. Walworth, RN; and Emily M. Tyre; Waukesha and Akron, Ohio

13 Transurethral insertion of a vaginal contraceptive suppository into the urinary bladder
by J.S. Mayersak, MD and Carl J. Viviano, MD, Wausau

16 Use of devices for mobility by the elderly
by Lori L. Brooks, MD; Jacqueline J. Wertsch, MD; and Edmund H. Duthie, Jr., MD, Milwaukee

Socioeconomic

21 *Public health*
The Wisconsin Women's Cancer Control Program
by Patrick L. Remington, MD, MPH; Linda Haskins; Judith Zvara; Barbara Henls-Lowe, MPH; Darren Bush, MA; April Cardell; and Susan Wood, Madison

26 Thompson signs 'Good Samaritan' bill

27 Legislators to introduce service corporation bill

Organizational

29 *Special series*
Teens and domestic violence
by Joanne Selkurt, MD, Whitehall

29 Reserve these dates for 1994

30 Annual meeting resolutions are due Feb 11

30 Notice to members of proposed constitutional amendment

32 Physician briefs

32 Deadline nears for Physician-Citizen of the Year award nominations

Our cover: "Premetheus Bound," by Peter Paul Rubens, 1577-1640. Our cover story begins on page 9.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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President's page

Chicken soup

THE COLD OF WINTER is upon us, as are seasonal "colds." Some days, every other patient seems to arrive with a red nose, wads of tissue and a raspy throat. A few try to insist on an antibiotic "cure," but most recognize the common cold as an uninvited irritant and are simply looking for relief. (It may be noted that most of these sufferers have experienced close encounters with young children, the incubators of humankind's winter bane.)

When I was a little girl, I had more than my share of these afflictions, and my parents were caring and indulgent. I remember mentholatum from a cracked green and white metal tube, which, when placed up my nostrils, gave glorious temporary relief. My father came home from work at night with the rare gift of a comic book, destined to allay my sneezing and coughing via the useful method of distraction.

In this column I offer remedies, old and less old, which may give your patients relief and you a Marcus Welby certificate. It is also comforting to know that over these many years some things barely change.

"For a cold in ye head, take sage leaves, rut them well, and apply them to ye nostrils in ye morning." --Pharmacist's book, 1650.

"Mix in a half glass of vinegar a spoonful of salt and half as much cayenne pepper. Warm 'til dissolved. Chill and drink." --Peter Cartwright, Methodist preacher, 1850.

"Hot drink, no food, bed rest, and a good book." --Sir William Osler, 1895.

"Boil ground black pepper with milk. Inhale the fumes." --Kentucky mountaineer, 1925.

"Enforced repose of a hot foot bath, innards awash with the tonic impact of lemon and honey heated in clear water." --M.F.K. Fisher, gourmand author, 1950.

"Stay at home in a warm room, and increase the moisture in the air ... drink plenty of fluids, take an aspirin or two at night..." --*AMA Family Medical Guide*, 1982.

Pauline M. Jackson, MD

"1/2 tsp. salt and 1/2 tsp. baking soda in a pint of water. Snuff up nose." --Wisconsin internist, 1990.

"After all is said and done, for a cold nothing can beat chicken soup. Put an experienced chicken in a pot with water, onions, carrots, peppercorns and a little salt. Cook 'til it falls apart. Strain. Discard fat. Save the wishbone to distract a sniffing child. Feed the overdone chicken and vegetables to a hungry pet. To the invalid, offer the broth steaming hot with a whole chili plus a halved large garlic clove swimming inside and thin slices of lemon on top. This is the cure for the common cold." --Wisconsin psychiatrist, 1994.❖

There are no small victories in the fight against heart disease.

American Heart Association

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EVP report

Is anybody listening?

As readers of this column know, over the past few years I've developed a pen-pal relationship with William B.A.J. Bauer, MD, a retired physician in Ladysmith, Wis, and Green Valley, Ariz. To be frank, I've learned a lot from Dr Bill, and his letters to me always cause me to pause, think and many times begin new actions.

The letter that follows was on my desk after my return in early January from the AMA State Legislation Meeting. Despite its moniker, those of us there spent the majority of our time discussing what to do about another Bill's plan to reshape the health care delivery system.

More on that in a moment, but first Dr Bill's letter.

Dear Tom:

Somehow I got thinking about your job, so much burdened at present with the national Medicare problem. It may be of little help to hear from a retired physician and yet you might be interested in a thumbnail sketch as viewed by one who has listened and participated in it for half a century.

Maybe too little but probably too late

The first problem is for how long physicians have permitted the problem to go unanswered. Way back in my doctor-father's time evidence of the accumulated conflicts were clearly in view. Again and again physicians were confronted with the reality that if they didn't do it the government would. In simple terms the threat was "socialized medicine."

Too much paper work

Gradually, because of little interest and even less activity by doctors, the government began invading *our* realm with rules and regulations that increased our paper work. This in turn increased our costs and in turn added to the costs to the patient.

Need for tort reform

Needs for controlling increasing malpractice costs were met with more enthusiasm and more actual activity but with very little success.

Another problem, not clearly brought out, is how often individuals demanded specialists as their right even when it was unnecessary.

Doctors overcharging

Then there is the real problem of doctors who took all the traffic would bear. And even worse, doctors who actually padded their bills.

Thomas L. Adams, CAE

This is not an over-simplification. It is what I call the need to focus on the realities that need be met rather than on the vague and emotional nuances. Clinton et al, let's give them credit for this, appear to be sincere is their aim. Their idealism and compassion are real but the reality of their answers leaves something to be wanted. In brief, idealism in all life is beautiful; but unless matched by reality the idealism becomes totally a dream.

And this lack of reality is well indicated by articles enclosed. You may already have seen them but if not you will find them a positive source for much needed attention. Please return at some later date for my own reference.

Best, Bill

Because of space I did not reprint

Continued on page 6

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

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Do You Know
The Physician-Citizen of the Year?

The State Medical Society of Wisconsin is asking the people of Wisconsin to nominate doctors for the Physician-Citizen of the Year award. The award was created to recognize the civic, cultural, economic, charitable and health care services provided by doctors to their local or state communities. Here are the criteria:

- The doctor must be a Wisconsin resident.
- The doctor must be either an MD or a DO.
- Except in unusual circumstances, the service to the community should be uncompensated. (Preference is given to current service over lifetime service.)
- Previous winners of the award are not eligible. *(The Medical Society will notify you if the doctor you nominate is a previous winner.)*
- The deadline for submitting nominations is **Feb. 14, 1994.**

How do you nominate someone?

Write to the Medical Society and provide:

- The name of the doctor.
- The doctor's home or office address.
- Your name and address.
- Why you think the doctor deserves to win: What has the doctor done for the community?
- Send to: Commission on Public Information, State Medical Society of Wisconsin, P.O. Box 1109, Madison, WI 53701.

Continued from page 4
the articles to which Dr Bill alluded; suffice it to say it was a collection of *Wall Street Journal* and *New York Times* articles on the failings of President Bill's health reform plan.

After thinking about Doctor Bill's letter and my discussions at the AMA meeting, I got mad. We know what's wrong with the system, we've told others what must be done to fix the system with the AMA's Health Access America plan and our own Wisconsin Care Plan. It makes you want to scream, "Is anyone listening out there?"

Politicians, whether it's the governor or the president, want to "solve" problems their way, which may not always be the best way. I think that's why both Governor Thompson's Health Care Partnership and President Clinton's reform plans are both in trouble. Neither one is right for the times.

We are now in the second quarter of the four-quarter football game. We have to talk with our elected representatives in Madison and Washington and make them understand the fundamental problems that Dr Bill spoke of in his letter that we've solved in Health Access America and Wisconsin Care.

If President Clinton and Governor Thompson will heed the words of Dr Bill, we can fix this thing and not harm the quality of care your patients have always received and deserved.✦

Letters

Support for generalist track in medical school

To the editor: I applaud the scholarly and thoughtful report on physician workforce by UW-MSN medical student Eric Gundersen. I strongly support his calls for curriculum reform and greater support for family practice programs. These solutions are now nearly consensus in America and deserve enhanced support from politicians in and out of medicine.

I would like to add to Gundersen's recommendations the possibility that general internal medicine (GIM) and general pediatrics (GP) also deserve enhanced support. There is, as yet, no consensus on an ideal role or title for generalists; there is a growing consensus that generalists must return to a central position in the system and deserve more respect, greater relative reward, and less management hassle. Family practice likely could not train all the generalists we need, so we must not fail to include GIM and GP in planning the future.

I especially liked Gundersen's call for a "primary care track" in undergraduate medical education. I have twice made similar proposals to our deans, both of which failed on the grounds of being "too radical."

As a model, review the history of primary care residency tracks in GIM and GP: they, too, were considered radical and accepted mainly because generous federal (HRSA) grants were available. Note also that internal medicine residencies are rapidly reforming themselves and are beginning to look much like "radical" primary care tracks. It took a crisis in internal medicine to get reforms from the naturally conservative institutions. But reflective conservatism in management is not the problem, but rather collective tendencies to deny problems and underestimate the values of establishing goals and monitoring outcomes of our educational enterprise.

"Radical" ideas are fundamentally important to social and scientific progress and are categorically worthy of respect, careful analysis, and limited trials. In this sense, I strongly join Eric Gundersen in calling for a generalist track in the curriculum of the University of Wisconsin Medical School, hopeful that the inevitable paradigm shift is coming soon.

--Norman Jensen, MD
Madison✦

Medicine ruled by the whims of tyranny

To the editor: The letter, "Is WIPRO the best we can do?" by David Murdock that appeared in the December issue of *WMJ* summarizes some of the frustrations we as physicians have experienced with WIPRO. Unfortunately, Dr Murdock describes the symptoms and not the disease.

Medicine is being assaulted today by the corrupt philosophy of collectivism, ie, the individual and his needs are superseded by society's needs and as such man has become programmed to sacrifice himself for the good of society. WIPRO's existence stems from this philosophy enacted when government created Medicare and Medicaid--two entitlement programs in which the "providee" obtains services using someone else's money. Both of these programs are justified by government because we as individuals must assume medical responsibility for those who cannot or choose not to.

The physician, like all productive people, is feeling the financial drain (look at your gross and take home paycheck) required to maintain this philosophy and at the same time he is being attacked by those who created and run these programs as greedy and dishonest. These arrogant bureaucrats provide no service (save for harassment) and product no goods; yet they, through the sanction of government, are telling you how to practice medicine through the shifting arrays of the paper chase syndrome.

Trying to approach WIPRO in a logical manner will only lead to frustration. WIPRO exists as a mercenary branch of the tyranny required by government to maintain these collectivist programs. The latest changes by WIPRO includes the study of statistical data of outcome based medicine. What will stem from this is cookbook medicine that will sanction those deemed outside the standard deviation.

Expecting WIPRO to fundamentally change is like asking the scorpion not to sting--he, like WIPRO, can't. It is in their nature to be what they are. What can be done to change our plight? We must reject collectivism for its corrupt nature of limiting man's freedom to pursue happiness. Unless we have the courage to take a stand and not allow "the sanction of the victim," our profession and society will be ruled by the whims of tyranny.

--James P. Fogarty, MD
Barron❖

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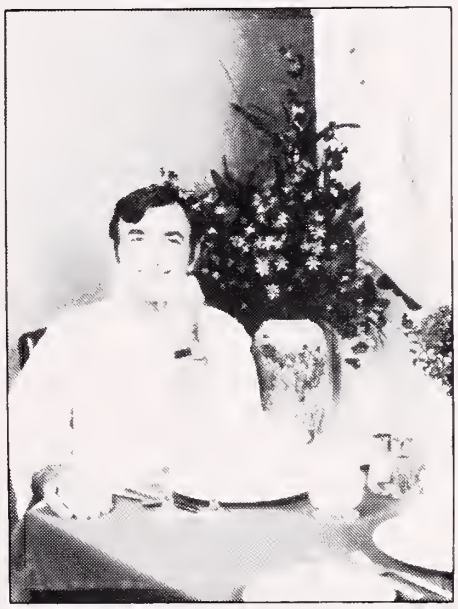

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Violence among family members has reached staggering proportions. Every year more than 2 million cases of child abuse and neglect are reported, between 2 and 4 million women are battered by their spouses, and between 700,000 and 1.1 million of the elderly population are abused.

The American Medical Association has formed a *National Coalition of Physicians Against Family Violence*. Through the *Coalition* the American Medical Association hopes to involve you in activities that address issues of child abuse, sexual assualt, domestic violence and elder abuse because you have the unique ability to identify the symptoms, first-hand. By joining the *National Coalition* you will be showing your concern about the effects of family violence and victimization, and will become a committed advocate within your community for the prevention of family violence.

Through the *Coalition* you will:

- be informed about local contacts and referrals
- become aware of local and regional resources
- be provided with information regarding model educational programs
- become aware of treatment guidelines and protocols.
- have access to newsletters, public education materials and other publications
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The only **cost** to you **is your commitment** to help curb this problem. Simply complete the membership application form below and mail to the Department of Mental Health, American Medical Association, 515 N. State Street, Chicago, IL 60610.

Yes, include my name in the *Coalition's* membership

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American Medical Association

Physicians dedicated to the health of America

The outcome status of chronic pain patients 4 years after multidisciplinary care

Timothy E. Tyre, PhD; Diane E. Walworth, RN; and Emily M. Tyre; Waukesha and Akron, Ohio

Thirty-three patients previously treated for a variety of chronic pain syndromes (largely non-surgical back problems) were selected for study on the basis of 2 years or greater post-discharge status. A patient profile was developed revealing an 86% successful return-to-work rate and minimal use of narcotics 4 years after discharge. In addition, there was relatively low use of either inpatient or outpatient medical services after treatment. These patient behaviors were specific goals of the pain management program in which these patients had participated. Interesting data were also collected on medication use after treatment and methods of pain control used most successfully. Selected outcome variables were also studied across specific diagnostic categories (surgical v non-surgical back problems, amputee pain, reflex sympathetic dystrophy, and others) for this group. In general, rather compelling positive outcomes are shown for the long-term effects of multi-disciplinary pain management. *Wis Med J.1994;93(1):9-12.*

Considerable attention has been paid to understanding the medical, economic, and social effects of chronic pain over the last several decades. Alternative treatment models, including behaviorally oriented, multi-disciplinary pain management programs, have been developed throughout the country to address these complicated cases. Waukesha Memorial Hospital has been a midwest leader in this area of occupational medicine, with a comprehensive pain service that has treated patients with chronic benign pain since 1978.

The profile of a chronic pain patient is remarkably similar throughout this country.[1] Typically, these patients suffer from unremitting pain following an industrial injury. A large percentage (60% to 80%) of these are back injuries, with or without surgical intervention. Over-use of narcotic analgesics, reactive depression and frequent use of and, in some cases, dependence on the health care system are also characteristics of this group. Many studies have been completed supporting the economic effects of lost work days, poor worker morale, and overall negative industrial production related to back injury and chronic pain.[2]

Studies were available in the early 1980s showing good short-term outcomes for behavioral treatment of these patients,[3] yet few have been offered showing extended outcomes. This study has focused exclusively on the long-term status of patients treated and discharged from a multidisciplinary pain clinic. Emphasis was on clarifying methods of pain control in everyday use of these patients. Occupational status, health system use patterns, and medication use were also studied. The sample was broken down by source of injury and principle diagnosis. Lastly, the group was analyzed by sex, age, and marital status.

Methods

Thirty-three chronic pain patients were randomly selected from a larger pool of previously treated patients with a study criteria requiring post discharge status of 24 months or greater. Trained hospital volunteers conducted a telephone interview survey using a standardized interview format. Respondent

Dr Tyre and Walworth are with the pain rehabilitation program at the Waukesha Memorial Hospital. Tyre is with the University of Akron Department Psychology in Akron, Ohio. Reprint requests to: Timothy E. Tyre, PhD, Waukesha Memorial Hospital, 725 American Ave, Waukesha, WI 53188-5099. Copyright 1994 by the State Medical Society of Wisconsin.

Table 1. — Demographic characteristics of selected chronic pain patients from long term follow-up study (discharge ≤ 24 months) (N=33).

	X = Age	No of years post discharge	% Married	% Single	% Return to work	% Using medical services post-discharge *Inpatient*	*Outpatient*
Males (N=20)	X=41.05	X=4.4	70% (14)	30% (6)	82% (14 out of 17)	10% (20-2)	45% (20-9)
Females (N=13)	X=35.08	X=4.0	76.9% (10)	23.07% (3)	92% (11 out of 12)	7.69% (13-1)	15.38% (13-2)
All Patients (N=33)	X=38.06	X=4.24	72.73% T (24)	27.27% T (9)	86.2% (25 out of 29)	9.09% (33-3)	33% (33-11)

Table 2. — Summary of selected outcome status by diagnosis for long term follow-up chronic pain patients (discharge greater than 24 months).

	X age M	X age F	% Female	% Male	% Work injury	% RTW	% Using medical services post-discharge In Pt	Out Pt
Post surgical /back N=8	43.0 Y	41.0 Y	37.5%	62.5%	F 66% M 60% Total: 62.5%	F 66% M 60% Total: 62.5%	F 33% M 20% Total: 25%	F 33% M 30% Total: 25%
Non surgical back N=17	39.7 Y	35.4Y	41.18%	58.8%	F 28% M 80% Total: 58.82%	F 100% M 70% Total: 82.35%	F 0% M 10% Total: 5.88%	F 42.86% M 50.0% Total: 47.06%
Post carpal tunnel N=2	NA	29.0 Y	100%	—	50%	100%	0	0
Reflex sym dystrophy N=2	31.5 Y	—	—	100%	100%	100%	0	50%
Amputee pain N=1	71.0 Y	—	—	100%	100%	NA	0	0
Cervical neck pain N=2	37.5 Y	—	—	100%	0%	100%	0	50%
Generalized pain syn N=1	—	27.0 Y	100%	—	100%	0%	0%	0%

compliance was 100%. Non- parametric statistical analyses were performed on selected demographics, treatment outcomes, and methods of pain control currently used by these patients

Results

Table 1 provides a demographic summary of the study sample. The average age of male patients was 41 years, females 35 years, and an overall average age of 38 years. The average number of years since discharge was similar for both men and women with mean scores of 4.4 years for males and 4.0 years for females. This sample included a majority of patients who reported intact marital status (72%). Notably high rates of successful return to work are noted with 82% of males returning and 92% of females. The group rate was 86% return to employment. A low rate of use of inpatient services is revealed at 9%, and althouqh outpatient services are higher at 33% these data suggest overall low rates of use compared to national averages for chronic pain patients.[4]

Table 2 breaks the study sample down by diagnosis. The largest number of patients are non-surgical back problems followed with post-surgical back injuries. Relatively high rates of return to work are reported by both these groups, although patients with non-surgical back injuries enjoy the highest level of successful return, with a response rate of 80%. A return-to-work rate of 62.5% is seen for patients with back problems requiring surgery. This lower level is likely attributable to enforced disability retirements. The additional diagnostic categories in the sample--which include carpal tunnel, reflex sympathetic dystrophy (RSD), and cervical neck pain--all show 100% successful return to work at 4 years past discharge. Review of Table 2 will also reveal the largest percentage of discharged patients used outpatient diagnostic services.

Table 3 provides a breakdown of medication categories in use by all patients. The study group is broken out by diagnosis for additional clarity. A 53% portion of patients with non-surgical back problems report "no pain medication" in use at the time of this follow-up. Diagnostic groups combined for this variable reveal 48% abstinence from pain medications. Approximately 10% of the study sample reports continued use of tricyclic antidepressant medications (low dosage) at greater than 24 months post discharge. Non-narcotic analgesics do continue to be used, yet at a relatively low level

Table 3. — Summary of daily medication use for long term follow-up chronic pain patients broken down by diagnosis (discharge ≥ 24 months).

	No pain medications	Tricyclic	Non-narcotic analgesia	Narcotic analgesia	Benzodiazepines
Post surgical back (N=8)	N=2 25%	— —	N=5 62.5%	N=1 12.5%	N=1 12.5%
Non-surgical back (N=17)	N=9 52.94%	N=2 11.76%	N=4 23.53%	N=3 17.64%	N=3 17.64%
Post carpal tunnel (N=2)	N=2 100%	— —	— —	— —	— —
Reflex sym/ dystrophy (N=2)	N=1 50%	N=1 50%	N=1 50%	— —	— —
Amputee pain (N=1)	— —	— —	N=1 100%	— —	— —
Cervical neck pain (N=2)	N=2 100%	— —	— —	— —	— —
Gen pain Syndrome (N=1)	— —	— —	— —	N=1 100%	— —
All patients (N=33)	N=16 48.48%	N=3 9.09%	N=11 33.33%	N=5 15.15%	N=4 12.12%

Table 4. — Summary of principle pain control methods for long term follow-up chronic pain patients broken down by diagnosis (discharge ≤ 24 months 1983-1988).

	Relaxation tech	Exercise	Body mechanics	Pacing	Distraction	TENS	Non-narc. analgesic	Narcotic analgesic	Other
Post surgical back (N=8)	N=1 12.5%	N=2 25%	— —	N=1 12.5%	N=1 12.5%	— —	N=1 12.5%	— —	N=1 25%
Non surg back (N=17)	N=8 47.06%	N=5 29.41%	N=1 5.88%	N=1 5.88%	— —	N=1 5.88%	N=2 11.76%	N=1 5.88%	N=1 5.88%
Post carpal tunnel (N=2)	— —	— —	— —	— —	— —	N=1 50%	— —	— —	N=1 50%
Reflex symdystrophy (N=2)	— —	— —	— —	— —	N=1 50%	— —	N=1 50%	— —	— —
Amputee pain (N=1)	— —	N=1 100%	— —	— —	— —	— —	— —	— —	— —
Cervical neck pain (N=2)	— —	N=1 50%	— —	— —	— —	— —	— —	— —	N=1 50%
Gen pain syndrome (N=1)	N=1 100%	— —	— —	— —	— —	— —	— —	— —	— —
All patients (N=33)	N=10 30.30%	N=9 27.27%	N=1 3.03%	N-2 6.06%	N=2 6.06%	N=2 6.06%	N=4 12.12%	N=1 3.03%	N=4 12.12%

(33%). A small percentage of these patients (13%) have reported continued use of muscle relaxant preparations.

Table 4 summarizes the principle forms of pain control in use by patients. A combination of relaxation techniques and regular exercise are reported as the most frequent sources of pain control. Other methods of pain management reported in smaller frequency of use include pacing of activity, distraction procedures, transcutaneous electrical nerve stimulation (TENS) and non-narcotic analgesic preparations. Interestingly, the largest diagnostic group of the sample (patients with non-surgical back problems) appears to rely most heavily on exercise and relaxation techniques.

Discussion

The care of chronic pain patients continues to be a necessary speciality service within industrial medicine. Back injuries and over-use trauma to the upper and lower extremities reflects a worker injury trend. Long-term outcome studies that demonstrate concrete evidence of patient behavior change are pivotal to evaluating the efficacy of multi-disciplinary behavioral treatment programs. The data revealed in this study supports positive long-term outcomes in several important areas, including successful return to work, minimization of health system over-reliance and decreased use of narcotic analgesics. The importance of consistent application of treatment techniques emphasizing exercise, relaxation procedures, pacing, and proper body mechanics are underscored.

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Transurethral insertion of a vaginal contraceptive suppository into the urinary bladder

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The accidental insertion of a contraceptive suppository containing the spermicidal detergent nonoxynol-9 into the urinary bladder constitutes an emergency that can be initially managed by the physician, but which is often misunderstood.

There are a variety of contraceptive suppositories available without prescription to the female patient under the trade names of Semicid, Conceptrol, and Encare. Each of the preparations has a similar concentration of nonoxynol-9. Semicid has 100 mg and Conceptrol has 150 mg of nonoxynol-9. Encare has 2.27% of nonoxynol-9 (table). These suppositories, when inadvertently inserted into the urinary bladder via the urethra, cause severe debilitating chemical cystitis secondary to the nonoxynol-9.[1-3]

Because the urinary bladder has more surface area than the vagina, these suppositories dissolve within 15 minutes after their insertion into the urinary bladder. The different cell lining of the bladder and the effect of various enzymes in the urine contribute to this rapid dissolving of the suppository and the absorption of the nonoxynol-9 into the systemic circulation. Theoretically, Conceptrol, with its higher amount of nonoxynol-9, would be capable of causing a more severe cystitis. The cystitis observed with Semicid, however, is so severe that it is difficult to imagine a cystitis more severe because of an increased amount of the nonoxynol-9 in the suppository. Prompt and effective treatment is imperative.

Some physicians under-estimate the danger of inserting these vaginal suppositories into the urinary bladder and think that these suppositories do not cause severe damage to the urinary bladder--a misconception reinforced when the physician contacts the poison control centers and is informed that nonoxynol-9 is a detergent not requiring specific care or treatment.

Extensive advertising by the companies producing these products states that they are an effective, safe, nonsystemic, reversible method of birth control. The effects and absorption of nonoxynol-9 would suggest a tempering of the claims of "safe and nonsystemic." Nonoxynol-9 has been used to lubricate latex condoms in various parts of the world in an effort to prevent the spread of AIDS, and significant irritation has been reported by prostitutes when these nonoxynol-9 lubricated condoms are used for anal, oral, or vaginal sex.[4] The nonoxynol-9 was capable of removing the fingernail polish of the workers in these studies. Bleeding and sloughing of a thin layer of the cells of the cervix have been reported to be caused by the nonoxynol-9. There is an increased risk of genital ulcers in females using nonoxynol-9 containing products.[5,6]

In animal studies using carbon-14 labeled nonoxynol-9, approximately 50% of the administered dose of the detergent is found in the systemic circulation within 6 hours. Nonoxynol-9 is eliminated unmetabolized in the urine or the bile.[7]

This systemic absorption information does not take into account the recommendation made by the companies producing the suppositories that another suppository should be placed in the vagina if intercourse does not occur within 1 hour of the initial insertion of the vaginal suppository. The systemic toxicity of the nonoxynol-9 is cumulative and dose-related. The effect of repeated doses of nonoxynol-9 would become important in its systemic toxicity. This would be particularly true if the intra-urinary bladder suppository was the second suppository used after an initial vaginal suppository.

The oleophylic and hydrophilic binding properties of nonoxynol-9 causes prolonged retention of the drug in the blood.[8] In animal studies, the intra-peritioneal injection of nonoxynol-9 for 5 days showed a significant increase in the collagen and DNA content in the liver and kidney.[9]

Up to 17 commercial oligomeric components of nonoxynol-9 are demonstrated with liquid chromatography evaluation, and their distribution varies slightly from manufacturer to manufacturer.[10] With the different oligomeric distributions, there would be a non-uniform toxicity in the different products, depending on the source of the nonoxynol-9. Nonoxynol-9 is nonylphenoxypolyethoxyethanol. Nonoxynol 4, 15, and 30 are used a pharmaceutical formulating aids as nonionic surfactants.[11]

Because the drug is excreted unchanged in the bile and urine, it would be appropriate to obtain appropriate renal and liver function studies on any patient who has in-

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serted a nonoxynol-9 containing suppository into the urinary bladder. This is because animal studies have demonstrated pathological changes in the kidney and liver from nonoxynol-9 in increased and repetitive doses.

Clinical presentation

Patients usually come to the emergency room within 2 hours of accidentally inserting a vaginal contraceptive suppository into the urinary bladder. Usually, there is a history of intoxication of the patient associated with the misplacement of the suppository.

The patient complains of severe urgency, stranguria, intensive suprapubic pain, and hematuria. Because of the severe acidity of the suppositories, alkalization of the urine is indicated. The pH of the spermicide is 3.35. For Conceptrol, the pH of the vaginal suppository is 4.5. The acidic nature of the suppositories is thought to contribute directly to the severe chemical cystitis encountered.

Physical examination may reveal marked urethral edema and urethral pain. The intensity of the pain the patients exhibit is greatly out of proportion to that expected by most physicians from the accidental placement of the suppository into the bladder. Urological evaluation demonstrates a marked reduction in the capacity of the urinary bladder with uninhibited bladder contractions. These patients have a severe hemorrhagic cystitis with pseudopolyp formation and marked elevation of the mucosal surfaces of the urinary bladder.

Biopsies of the urinary bladder have demonstrated that there may be eosinophilic infiltration into the bladder wall. Associated cutaneous fixed drug eruption has been reported.

The poison control center's recommendation was that these suppositories contain a detergent-like substances and no specific therapy was recommended.

Recommendations

Because the patients are usually seen 15 minutes after insertion of the contraceptive vaginal suppository into the urinary bladder, the suppository will have already dissolved and, in the semi-liquid form, had extensive contact with the walls of the urinary bladder.

A three-way catheter should be inserted into the urinary bladder, and the bladder emptied. Irrigation with an alkaline solution should be initiated as has been suggested by Gottesman because of the severely acidic nature of the suppositories. The alkaline solution irrigation may assist in the reduction of the symptoms and duration of the chemical cystitis.

Broad spectrum antibiotic coverage should be instituted along with antispasmodic therapy for the uninhibited bladder contractions. The use of intravenous steroids at high doses is recommended. The patient should be hospitalized and an oral steroid tapering dose with prednisone be started.

Urological evaluation should be performed since these patients have been reported to have marked submucosal bladder hemorrhage

Composition of vaginal contraceptive suppositories.

	Semicid	Encare	Conceptrol
nonoxynol-9	100 mg	2.27% (no mg given)	8.34% 150 mg
Repeat recommendation	within 1 hr or with each act of intercourse	within 1 hr or with each act of intercourse	within 1 hr or with each act of intercourse
How supplied	Strip package of 10	boxes of 12	10 inserts
Inactive ingredients	benzethonium chloride citric acid D&C Red #21 Lake D&C Red #33 Lake Methylparaben Polyethlene glycolsodium water.	fragrance lactalbumin polyethlene glycols potassium coco-hydrolyzed animal protein bicarbonate sodium lauryl sulfate sodium tartrate tartaric acid	Lauroampho-diacetate sodium, Trideceth sulfate polyethlene glycol 1000 Polyethlene glycol 1450, povidone.

and blood clot formation in the bladder. Significant hemorrhage from the bladder can occur. Because a significant absorption of the nonoxynol-9 can occur via the bladder mucosa, appropriate liver and renal function studies should be obtained to serve as baseline studies during the treatment of the patient.

It is obvious that these nonoxynol-9 containing suppositories do not behave as a benign detergent in the urinary bladder, but are capable of causing severe and possibly permanent bladder damage. There was a significant reduction in the capacity of the urinary bladder reported in some of the cases with nonoxynol-9 intravesical suppository insertion. The bladder symptoms persisted for up to 6 weeks.

Physicians should appreciate the severe nature of the problem and with vigorous treatment an effort to reduce the severe symptoms and long-term potential problems can be accomplished. The treatment must be instituted promptly on the arrival of the patient with the vaginal suppository in the urinary bladder syndrome.

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Use of devices for mobility by the elderly

Lori L. Brooks, MD; Jacqueline J. Wertsch, MD; and Edmund H. Duthie, Jr., MD, Milwaukee

Our study examined the use of devices for mobility by the elderly. We looked at whether the device was prescribed, who prescribed it, and how it was obtained. Seventy elderly people, age 75 years or older, who were current users of canes, walkers, or wheelchairs were interviewed. Seventy-one percent of the devices had been prescribed. The prescribed devices were chosen 45% of the time by physical therapists, 32.5% by physicians, and 22.5% by nurses. An exceptionally high percentage of wheelchair users (93%) in the skilled care facility may reflect economics (wheelchair and standard walkers are provided free) and perceived socialization benefits. This study shows that many elderly begin using devices for mobility on their own (94.3%). Clinicians need to be alert to these non-prescribed devices to assure their appropriateness and safe use. *Wis Med J.1994;93(1):16-20.*

As early as 2830 BC devices for mobility were used. A carving on the entrance of an Egyptian tomb shows Hirkouf leaning on a crutch.[1] In medieval times, the social implications of crutch use was appreciated as illustrated by the legend of Pope Sixtus Quint (1585). He allegedly used crutches to portray feebleness and vulnerability when being considered for office. After being elected to succeed Gregory XIII, he immediately discarded the crutch in triumph.[1] Today, in the United States there is widespread use of canes, walkers, and wheelchairs.

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The use of mobility aides by the elderly in our society is not only very common but also very costly.[2] The process by which elderly individuals obtain mobility devices varies. They may simply start using a cane bought at the local drugstore or found in the attic. In such cases, it has been noted that an incorrect length or inappropriate handle can be dangerous.[3-5] Sainsbury found that 18 of the 24 individuals who had fallen while using their canes had canes of incorrect length.[6] A wheelchair can also be a source of morbidity if prescribed and used incorrectly.[7,8] Thus, it appeared of interest to examine not only what devices for mobility were actually being used by a group of elderly, but also whether the device was prescribed, who prescribed it, and how it was obtained.

Methods

Seventy elderly people were interviewed. Fifty-eight of the 70 resided in a skilled nursing facility, while the remaining 12 resided in an intermediate care nursing facility. These two nursing homes were available for participation in this study and were not chosen for comparison purposes. The individuals were chosen by the head nurse on each floor using inclusion criteria:

1) age 75 or older;
2) a current user of a cane, walker or wheelchair; and
3) capable of communicating with the interviewer.

The Short Portable Mental Status (SPMS) questionnaire[9] was administered to each participant, and a minimum score of 7 out of 10 was required for inclusion in the study. A score of 7 was chosen in accordance with the published scoring guidelines,[9] as the majority of the participants had up to an eighth-grade education.

Human Research Review Committee procedures were followed, with a consent form signed by each individual prior to the interview. A questionnaire was administered inquiring about which assistive devices they had ever used, whether they are currently using them or had done so previously, when they began using them, where they obtained them, cost factors involved, if they are effective, and whether they were prescribed. The designation of prescribed v non-prescribed was not applied solely to prescriptions by physicians. If an assistive device was chosen for a resident by a physician, physical therapist, or nurse, it was considered prescribed. If no health care professionals were involved in choosing or initiating device use, it was considered non-prescribed. The data was statistically analyzed by frequency analysis and cross tabulation. Statistical significance was determined using the chi square test with $p < 0.05$.

Results

Non-prescribed devices were used by 94.3%. Of these, 34.3% had exclusively used only non-prescribed devices, and 60% have used both prescribed and non-prescribed devices. The prescribed devices were

chosen 45% of the time by a physical therapist, 32.5% by a physician, and 22.5% by a nurse. Manual wheelchairs were the devices used most frequently (87.1%), with standard walkers being used second most frequently (60%) and straight canes third (54%).

How the mobility devices were obtained was examined. Interestingly, 10.1% of the devices were in the individual's possession before

Table 1. -- Mobility devices used, by who prescribed the device, cross tabulation.

		MD	PT	Nurse	Self	Family	
Rolling walker	n	2.0	7.0	0.0	2.0	0.0	11.0
	% of total						6.5
	% of row	18.2	63.6	0.0	18.2	0.0	
	% of col	5.1	13.0	0.0	5.3	0.0	
Standard walker	n	15.0	17.0	2.0	6.0	4.0	44.0
	% of total						26.0
	% of row	34.1	38.6	4.5	13.6	9.1	
	% of col	38.5	31.5	7.4	15.8	36.4	
Large quad cane	n	0.0	2.0	0.0	0.0	0.0	2.0
	% of total						1.2
	% of row	0.0	100.0	0.0	0.0	0.0	
	% of col	0.0	3.7	0.0	0.0	0.0	
Small quad cane	n	4.0	1.0	0.0	1.0	3.0	9.0
	% of total						5.3
	% of row	44.4	11.1	0.0	11.1	33.3	
	% of col	10.3	1.9	0.0	2.6	27.3	
Straight cane	n	9.0	7.0	0.0	21.0	1.0	38.0
	% of total						22.5
	% of row	23.7	18.7	0.0	55.3	2.6	
	% of col	23.1	13.0	0.0	55.3	9.1	
Lofstrand crutches	n	0.0	0.0	0.0	1.0	0.0	1.0
	% of total						0.6
	% of row	0.0	0.0	0.0	100.0	0.0	
	% of col	0.0	0.0	0.0	2.6	0.0	
Axillary Crutches	n	1.0	0.0	0.0	0.0	0.0	1.0
	% of total						0.6
	% of row	100.0	0.0	0.0	0.0	0.0	
	% of col	2.6	0.0	0.0	0.0	0.0	
Manual wheel-chair	n	7.0	20.0	25.0	7.0	3.0	62.0
	% of total						36.7
	% of row	11.3	32.3	40.3	11.3	4.8	
	% of col	17.9	37.0	92.6	18.4	27.3	
Light wheel-chair	n	1.0	0.0	0.0	0.0	0.0	1.0
	% of total						.6
	% of row	100.0	0.0	0.0	0.0	0.0	
	% of col	2.6	0.0	0.0	0.0	0.0	
Total	n	39.0	54.0	27.0	38.0	11.0	
	%	23.1	32.0	16.0	22.5	6.5	

being used. Many were left from deceased spouses, and several were bought at the 1913 Worlds Fair. Gifts from family or friends accounted for 8.3% of the devices. Overall, 37.9% of the devices were purchased by the user and 41.4% were provided by the nursing home. Nursing homes most commonly supplied manual wheelchairs (64.3%), with standard walkers being second (22.9%). Some straight canes which had been donated to the nursing home were dispersed to some of the residents.

Cross tabulation (Table 1) revealed a variation among devices chosen and who chose them. Nurses chose manual wheelchairs 92.6% of the time. Straight canes were chosen by patients themselves 55.3% of the time. Families chose standard walkers most frequently (36.4%), with their second choice being either a small quad cane or manual wheelchair 27.3% of the time.

There were 169 devices used by the 70 people interviewed, with 120 devices being currently used (Table 2). Many individuals had used several different devices. Manual wheelchairs were the most common mobility device ever used (61), with standard walker being second (42), and straight cane third (38).

Analysis of when each device was used showed that 63% of straight canes were previously used, but the vast majority of manual wheelchairs (96.7%) were being used at the time of the study.

The most common reason stated by the patient for using a manual wheelchair in the skilled facility was arthritis or unsteadiness (18.2%). Strokes and frequent falling were second and third respectively. Most of these wheelchairs (54.5%) were used all the time, while 16.4% were used for pushing and 14.5% were used only when doing "long distances."

Discussion

There are many factors other than a medical prescription that may determine what mobility device is actually used by a person. For the elderly, receiving a cane can be perceived as a right of passage into old age. Grandparents receive ornate canes as presents. Canes may be handed down in the family. Some elderly use canes to proclaim their frailty. In contrast, some elderly perceive the cane as a defensive weapon.[5] A relative's cane may be retrieved from the attic. Or a cane may be bought at the local drugstore.

The purpose of our study was to examine what devices for mobility were being used by the elderly, whether the device was prescribed, who prescribed it, and how it was obtained.

Mobility devices are not difficult to obtain. Many pharmacies and home health care stores provide myriad devices to purchase without physician prescription. It is also important to note the "recycling" of devices prescribed for other people. It is not uncommon for devices to be passed on to elderly neighbors or friends when a spouse or parent either dies or cannot use the device any longer. Because these devices are expensive, they are often stored in the attic and retrieved for different purposes at a later date.

We found that the majority (71%) of all the devices ever used by this elderly population were prescribed by a health care professional. There was, however, a high frequency of multiple device use (169 devices used by 70 subjects). Most (94.3%) had used both prescribed and non-prescribed devices. Only a very few (5.7%) had used only prescribed devices. Thus, it appears wise to carefully inquire about all devices used, as usually the elderly have more than one ambulation aid, of which it is likely that at least one was not prescribed for that individual. These individuals need to be encouraged to bring all devices either to the physician's office or to a therapist to ensure that the appropriate measurements were made and that the patient uses the device appropriately.

We also examined who prescribed the devices used by the elderly in this study. This was determined by patient report. The designation of prescribed v non-prescribed was not applied solely to prescriptions by physicians, but if an assistive device was chosen for a resident by a physician, physical therapist, or nurse, it was considered prescribed. In our population, we found that the prescribed devices were chosen by physical therapist 45% of the time, by a physician 32.5% of the time, and by nurses 22.5% of the time. There was a difference in the prescribing patterns of these health care providers. The physical therapist chose the wheelchair and standard walker almost equally. Nurses gave manual wheelchairs almost exclusively, while the physician was more likely to chose a standard walker. The nursing staff pointed out that they had ready access to wheelchairs, but requesting a cane or walker required significantly more time because they had to be obtained from the physical therapy departments. The elderly often perceived the nursing staff as giving them a wheelchair to use so that they would not fall.

An interesting observation made earlier by others was that the wheelchair can play an important social role in the nursing home.[10] In the nursing home, the use of mobility devices may not simply reflect functional needs of the residents. Pawlson observed that in a nursing home multiple social and environmental factors influenced the decision to use a wheelchair.[10] For example, he reported that the wheelchair allowed the nursing home residents to sit wherever they wanted and thus they could socialize more independently. The wheelchair gives them more control over their environment because it gives

them the ability to chose their "sitting area." He noted that nursing home residents described a perception of the wheelchair improving not only their mobility, but also their feeling of independence, sense of physical well-being, and sense of emotional well-being.[10]

We found considerably greater wheelchair use in the skilled nursing facility than in the intermediate care facility. This is not surprising since in Wisconsin skilled nursing facilities must provide manual wheelchairs free of charge to residents who require one, while those residents in the intermediate care center were required to purchase any devices that they needed. The vast majority of the rolling walkers currently used belonged to individuals at the intermediate care facility, while the vast majority of standard walkers and manual wheelchairs currently used were at the skilled care facility.

Of those people using manual wheelchairs in the skilled facility 14.8% just pushed it and never sat in it. They were using the wheelchair like a rolling walker. This reflected the economic reality of being in a skilled care facility where they could be provided a wheelchair free but would have to purchase their own rolling walker. In addition, it reflects the very practical fact that by pushing a wheelchair instead of using a rolling walker, the individual will always have a place to sit when they get to their destination. Using a wheelchair as a rolling walker is not safe; the wheelchair has more momentum and no stopping mechanism. The danger of using a wheelchair in this way needs to be appreciated by health care professionals who encourage patients to walk behind their wheelchair.

Conclusion

The use of adaptive assistive devices by nursing home residents is

Table 2. -- Frequency analysis of all devices used by facility and previous v current use.

Device		Combined			Skilled		Nonskilled	
		Ever used	Now used	Prev used	Now used	Prev used	Now used	Prev used
Rolling walker	n	11.0	9.0	2.0	1.0	1.0	8.0	1.0
	%	6.5	5.3	1.2	50.0	50.0	88.9	11.1
Standard walker	n	44.0	31.0	13.0	29.0	12.0	2.0	1.0
	%	26.0	18.3	7.7	70.7	29.3	66.7	33.3
Large base quad cane	n	2.0	2.0	0.0	1.0	0.0	1.0	0.0
	%	1.2	1.2	0.0	100.0	0.0	100.0	0.0
Small base quad cane	n	9.0	4.0	5.0	3.0	5.0	1.0	0.0
	%	5.3	2.4	2.9	37.5	62.5	100.0	0.0
Straight cane	n	38.0	14.0	24.0	13.0	20.0	1.0	4.0
	%	22.5	8.3	14.2	39.4	60.6	20.0	80.0
Lofstrand crutches	n	1.0	0.0	1.0	0.0	1.0	0.0	0.0
	%	0.6	0.0	0.6	0.0	100.0	0.0	0.0
Axillary crutches	n	1.0	1.0	0.0	1.0	0.0	0.0	0.0
	%	0.6	0.6	0.0	100.0	0.0	0.0	0.0
Manual wheelchair	n	62.0	60.0	2.0	54.0	2.0	5.0	1.0
	%	36.7	25.5	1.2	96.4	3.6	83.3	16.7
Light wheelchair	n	1.0	1.0	0.0	0.0	0.0	1.0	0.0
	%	0.6	0.6	0.0	0.0	0.0	100.0	0.0

n = # of devices
% = percentage of devices

exceedingly common. The reasons for device use are complex and often reflect psycho-social aspects. Devices are often self-prescribed. It is important for physicians who care for the elderly to inventory the devices used to ensure their appropriateness and safe use.

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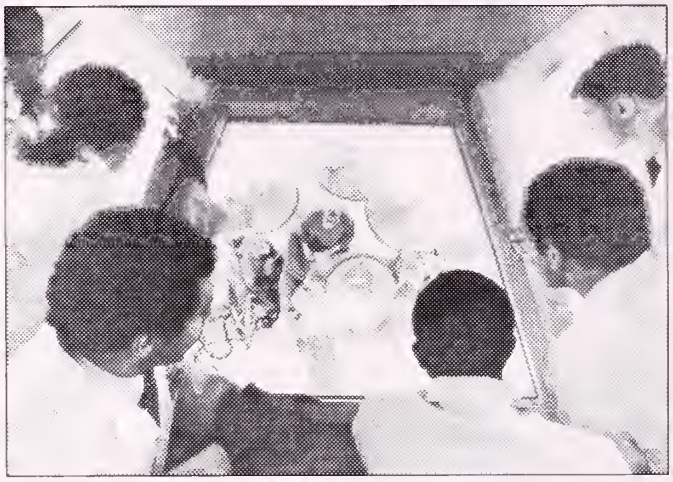

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Public health

The Wisconsin Women's Cancer Control Program

Patrick L. Remington, MD, MPH; Linda Haskins; Judith Zvara; Barbara Nehls-Lowe, MPH; Darren Bush, MA; April Cardell; and Susan Wood, Madison

The Wisconsin Division of Health, together with a broad-based coalition of organizations and individuals from throughout the state, has established the Wisconsin Women's Cancer Control Program. This program is funded by the Centers for Disease Control and Prevention (CDC), as part of the 1993 National Breast and Cervical Cancer Early Detection Program.

The goal of the Women's Cancer Control Program is to reduce mortality from breast and cervical cancer by increasing the number of low-income and under-served women 40 years of age and older who are routinely screened, and by improving the quality of screening, referral, and follow-up. This report documents the public health burden from breast and cervical cancer and describes how the new Women's Cancer Control Program will be implemented in the state.

The public health column is not reviewed by the *WMJ* editorial board. Dr Remington is the chief medical officer for chronic disease in the Bureau of Public Health, Wisconsin Division of Health and the program's principle investigator. Haskins is the manager, Zvara and Nehls-Lowe are health educators, Cardell is the program assistant, and Bush the research analyst for the program. Wood is the chief of the Section of Chronic Disease Prevention and Health Promotion, Bureau of Public Health. Reprint requests to: Patrick L. Remington, MD, Wisconsin Division of Health, 1414 E Washington Ave, Room 96, Madison, WI 53704-3041. Copyright 1994 by the State Medical Society of Wisconsin.

Breast and cervical cancers in Wisconsin

Each year, nearly 1,000 Wisconsin women die from breast and cervical cancer. It has been estimated that as many as one third of these deaths could be prevented through the use of routine mammography and Papanicolaou tests.[1]

Despite the existence of safe and effective screening methods, many poor, minority, and older women fail to benefit from early diagnosis and treatment.[2,3] One major barrier to screening is the high cost of the test for women who are not insured or women who have a large deductible. In addition, many women believe that they are not at risk or that screening is necessary only if symptoms are present.[4,5]

In response to the continuing burden from breast and cervical cancer, in 1990 Congress passed the Breast and Cervical Cancer Mortality Prevention Act and appropriated $30 million to the CDC to develop the national breast and cervical cancer control program. The current funding level is $78 million, supporting program activities in 45 states (see map).

Wisconsin Women's Cancer Control Program

In September 1992, the CDC granted funds to the Wisconsin Division of Health (DOH) to develop the capacity to implement a statewide system for delivering breast and cervical cancer services. As part of this small grant, the DOH worked with organizations and individuals from around the state to examine existing service capacity and to develop a preliminary proposal.

In September 1993, the CDC awarded the DOH a $15 million, 5-year grant to further develop and implement comprehensive breast and cervical control activities through the Wisconsin Women's Cancer Control Program. Wisconsin is now one of 18 states that will deliver full-service early detection screening programs. Another 27 states are now funded to build the capacity to carry out full-service screening programs.

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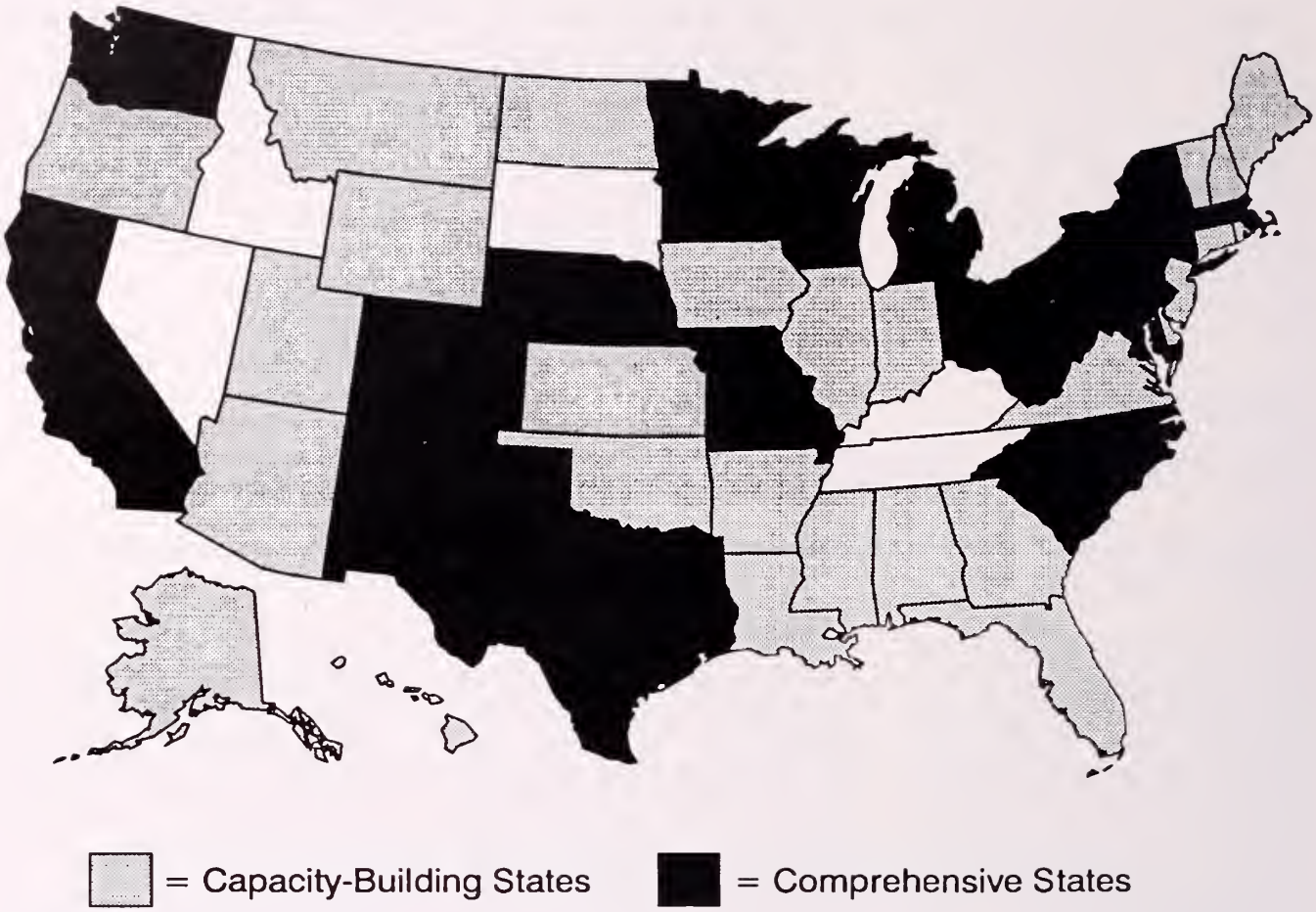

Fig.--National breast and cervical cancer early detection program, 1994.

Continued from preceding page

The Women's Cancer Control Program will establish a comprehensive breast and cervical cancer control program in Wisconsin to significantly increase the proportion of older, low-income women who are screened for breast and cervical cancer. This supports Wisconsin's Public Health Agenda for the Year 2000 to reduce mortality by increasing the number of women who are screened using mammography and Papanicolauo tests.[6]

The program will both develop a statewide comprehensive plan for breast and cervical cancer control, and provide screening services through contracts with providers throughout the state. The program has the following components:

Coalition building. Convene a statewide breast and cervical cancer coalition with a broad array of providers, community and local governmental leaders, and other representatives in both the public and private sectors. Establish work groups in each of the areas listed below to develop a statewide comprehensive plan for breast and cervical cancer control and to advise the DOH on the Women's Cancer Control Program.

Public education. Develop the best strategies to educate the target populations about breast and cervical cancer and inform them about the availability of screening. Identify methods of supporting local efforts to recruit high risk women into the screening program.

Professional education. Identify the best methods of informing health care providers about the screening program, and identify training and education needs and methods for physicians, nurses and allied health professionals.

Quality assurance. Advise the DOH on program operations issues such as detailed quality assurance language for screening agreements and effective enforcement mechanisms. Identify strategies to enhance quality assurance through legislation, administrative rules, provider organizations policies and professional education.[7]

Surveillance and evaluation. Recommend ways to enhance the existing

Continued on page 24

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Continued from page 22
breast and cervical cancer surveillance system. Review and make recommendations about the system designed to track screening and follow-up activities for services reimbursed by the program.

Service delivery. Address issues related to delivery of existing screening services and to integration of the new Women's Cancer Control Program into existing health care delivery systems. These issues include: identifying and recruiting appropriate target populations; reimbursement; provider recruitment; client eligibility; and basic components of the screening program.

During the first year of the program, the DOH will work with local public health departments throughout the state to develop systems to identify low-income women needing to be screened, refer for screening, assure appropriate treatment and follow-up. By the second year of the program, an estimated 16,000 low-income women will be screened annually for breast and cervical cancer.

The reimbursable screening services include physical breast examination, screening and diagnostic mammography, fine needle aspiration, Papanicolaou testing, pelvic examination and colposcopy and colposcopy-directed biopsy. This program will enssure appropriate referral and follow-up for women screened through a tracking and follow-up system.

This program will target women age 40 years and older. The majority of program resources will be directed toward economically disadvantaged and ethnic minority women. Special attention will be given to women who are uninsured or under-insured or living in areas of the state with limited cancer screening and treatment resources.

The Women's Cancer Control Program will be collaborating with local health departments, tribal agencies, family planning clinics, tribal health clinics, federally funded community health centers, public hospitals, private practitioners, community-based organizations and other health care providers who serve the economically disadvantaged population.

Conclusion

The DOH has demonstrated an ability to work with numerous state-

Continued on page 26

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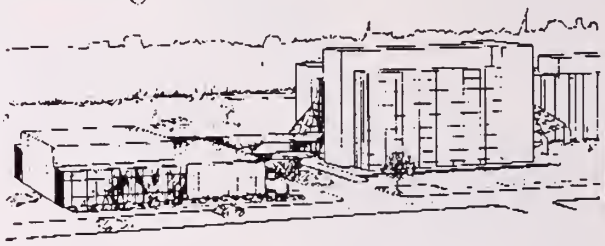

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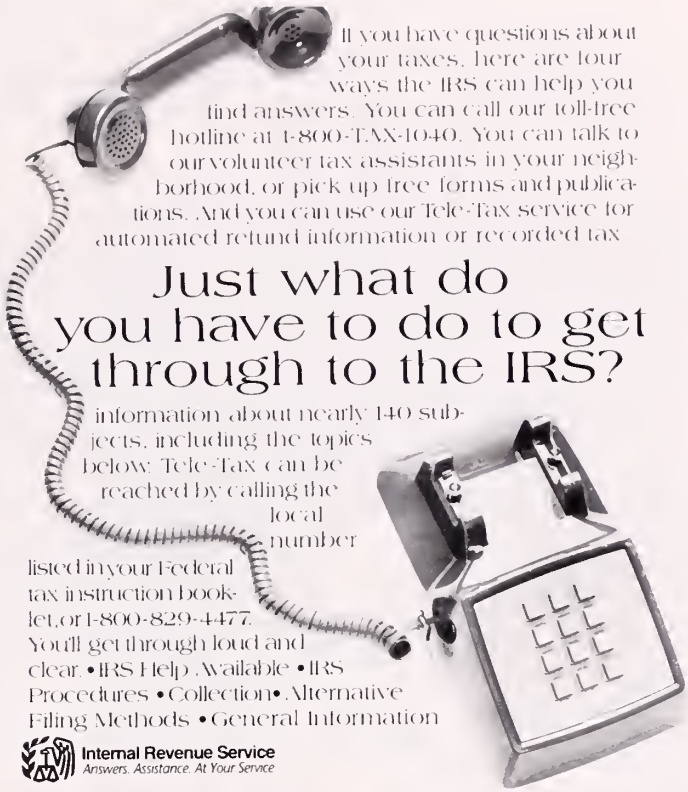

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Continued from page 24
wide and community organizations toward a common goal.[8] The Women's Cancer Control Program has been enthusiastically received by community-based organizations and health care professionals in Wisconsin. The program will build on this foundation and integrate existing efforts into a comprehensive program. Only through a comprehensive program such as this will it be likely to achieve the year 2000 objectives of reduced mortality from breast and cervical cancer.

Acknowledgements
Part of this work was supported through a cooperative agreement from the CDC (#U57/CCU509699-01).

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Thompson signs 'Good Samaritan' bill

After several years of intensive effort, the "Good Samaritan" bill for physicians, has passed the Legislature and been signed into law by Gov Thompson. The new law, formerly AB 251, introduced by Rep. Spencer Black (D-Madison), provides that physicians who volunteer their services at school athletic events will be immune from civil liability for acts or omissions in rendering care to participants at athletic events or contests, so long as the care is given at the site of the event, during transportation to a health care facility from the event, or in a locker room immediately before, during or after the event.

William Bartlett, MD, a Madison pediatrician and the driving force behind the bill, witnessed the governor's signature. Bartlett is a team physician for LaFollette High School in Madison. In addition to the SMS, the bill was supported by the WIAA, the Wisconsin Athletic Directors Association and the Wisconsin School Board Association. It is hoped the new law will increase the number of physicians willing to volunteer their services as team physicians for school-sponsored sports.

When the bill passed the Assembly in May, it extended immunity only to physicians. Despite SMS objections, the Senate amended the bill to provide that chiropractors, nurses, emergency medical technicians and physician assistants would be covered during specific events. Officials of the Badger State Games requested that these providers be included because they serve as volunteers at the Badger State Games. The addition of this amendment required the Assembly to revisit the bill. At this point, the Wisconsin Dental Association requested that dentists be included, so the Assembly attached another amendment to fulfill this request. The Senate concurred in the Assembly amendment and forwarded the bill to Thompson.❖

William Bartlett, MD (l) watches Gov Thompson (s) sign AB 251.

Legislators to introduce service corporation bill

Assembly Speaker Walter Kunicki and Joint Committee on Finance Co-Chair Joe Leean are authoring legislation that would permit various health care practitioners to become shareholders, directors and officers in physician-organized service corporations. Under the bill, podiatrists, physician assistants, physical therapists, occupational therapists, respiratory care practitioners, pharmacists, optometrists and nurses would be able to participate as shareholders with physicians in service corporations. Current law permits only persons with the same license, certification or registration to organize service corporations.

The SMS has significant concerns about the proposed legislation. The proposed change would gut the current ban against the corporate practice of medicine by allowing non-physicians to become owners of a medical practice, thereby enabling the financial and political interests of the corporation to override the interests of the patient. Additionally, the bill would represent a profound expansion of the potential liability of the Patients Compensation Fund for losses due to the negligence of non-physician providers, as the physician shareholders in the corporation, as members of the Patients Compensation Fund, could be held liable for the negligence of non-physician members. The Patients Compensation Fund is already facing a substantial deficit and this proposed expansion in the service corporation law will only increase that deficit.

Although not yet formally introduced, the service corporation proposal has garnered the support of a considerable number of legislators. The bill is expected to receive legislative consideration before the conclusion of the 1993-1994 session. ❖

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

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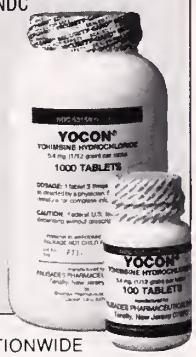

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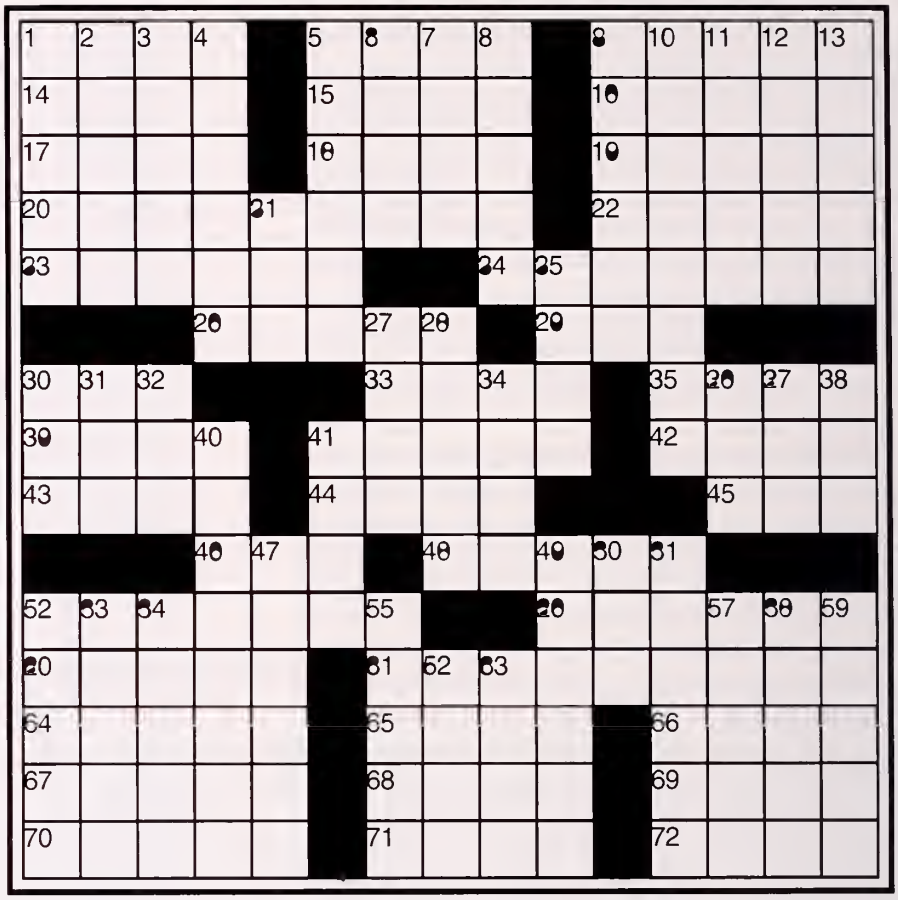

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5 Produce a remission
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15 Biblical lions
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18 Mature
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20 Kind of a twin
22 Deliver in second month
23 Ridicule
24 Layers of eye
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29 ETOH>0.1% (slang)
30 Dental prosthesis
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4 Abnormal bulge
5 Diseased teeth
6 Gouty acid
7 River bank
8 Asses (Ger.)
9 Not acid
10 Non-functioning islets
11 Landed estate
12 Prefix:within
13 Selectivity
21 49ers hope for
25 Iron-____ contract
27 Mexican falafel
28 Denude
30 Greek letter
31 Abet
32 Thickness
34 Provide inner cover
36 Inspire fear
37 Enzyme
38 Head tutor
40 May cause sneezing
41 Prefix:vinegar
47 Buries
49 Easily hurt
50 Fodder plant
51 Dried grape
52 e.g. linguini
53 Accessory in a church
54 A rope
55 Thong
57 Net
58 Provide for
59 Support
62 Breath sound
63 Pier

Solution on page 34

Special series

Teens and domestic violence

Joanne Selkurt, MD, Whitehall

TEENAGERS ARE OFTEN victims of domestic violence. Domestic violence is not only seen in marriages and "living together" arrangements, it is also seen in the high school dating scene.

There was a time when a woman who is in an abusive relationship did not even know her partner. How did she get herself into such a situation in the first place? Are there things that she should have been aware of in the dating days that could have warned her of things to come?

First, young women must be made aware of the obvious--that she is already in an abusive relationship if her date is:

- verbally abusing her--calling names, threatening, or putting her down;
- emotionally attacking her--she never does anything right or knows what she's talking about (he, on the other hand, is always right);
- physically attacking her or her property; or
- raping her--forcing her to have sex when she doesn't want to.

The stereotypic young woman who gets herself into an abusive relationship is the one with low self esteem who doesn't date much. She suddenly finds herself in a situation where a lot of attention is being paid to her. It is very flattering that her boyfriend is concerned about who she sees or talks to and is very "protective" of her. "He must really love me," is the thought she has, not recognizing the situation for what it is--his control over her.

Every girl, not just the stereotype, has to realize that she can find herself in an abusive relationship. It doesn't happen just to other people.

There are subtle ways a girl can tell if her date may be a potential abuser. She should watch for these signs:

- Does he have a bad temper and take his anger out on things?
- Is he excessively jealous?
- Does he drink alcohol or abuse drugs?
- Does he always have to be right?
- Is he cruel to animals?
- Does he push the relationship too far too fast?
- Is he fascinated by weapons?
- Is he too physical, like grabbing so hard that he leaves marks?
- Does he pressure her to disobey her parents?
- Is there just a "gut feeling" that frightens her about him?

Young women need to know that the abusive partner will not change over time. She cannot change him.

This information needs to be shared with high school girls so that they will get out of a potentially abusive relationship while they still can.❖

Reserve these dates for 1994

MARK YOUR calendars now for SMS annual meeting to be held April 13-16, 1994, in Milwaukee.

Some highlights of the 1994 agenda include:

- *April 13*--8 a.m.--SMS Board meeting; 12:30 p.m.--50 Year Club; 4 p.m.--First session of SMS House of Delegates; 6:30 p.m.--WISPAC reception; and 8:30 p.m.--YPS reception;
- *April 14*--8:30 a.m.--Reference committees begin work; 3:30 p.m.--House of Delegates; and 6:30 p.m.--Inaugural ceremony;
- *April 15*--7 a.m.--Caucuses; 8:30 a.m.--House of Delegates; 1 p.m.--Scientific programs; and
- *April 16*--8 a.m.--Scientific programs begin. ❖

Annual meeting resolutions are due Feb 11

RESOLUTIONS TO THE annual meeting of the SMS must be submitted in proper form to the executive vice president's office no later than two months prior to the first session of the House of Delegates. Therefore, resolutions must be received no later than Friday, Feb 11, 1994.

All resolutions calling for studies, conferences or other activities resulting in an expense or reduction of income must include a fiscal note. The EVP's office will prepare fiscal notes.

Note: The "resolve(s)" should be self-explanatory as an action statement. In preparation of the resolutions, review the following quotation from *Sturgis*:

> "Often a resolution is prefaced by statements, each introduced by the word `whereas,' that state the reasons for the resolution. The statements contained in the whereases are of no legal effect and sometimes are the cause of disagreement. Members frequently attempt to debate and amend these prefacing statements, often to the neglect of the main resolution."

Also, for the House to adequately conduct its business, the first session of the House of Delegates will take place at 4 pm on Wednesday, April 13, 1994. Reference committees will meet on Thursday, beginning at 8:30 am, and the second session of the House will begin on Thursday at 3:30 pm.❖

Notice to members of proposed constitutional amendment

THIS NOTICE IS GIVEN to SMS members, pursuant to Article XIII of the SMS Constitution, of the following proposed constitutional amendment introduced at the 1993 SMS annual meeting of the House of Delegates. This amendment may be taken up as old business at the second session of the 1994 SMS annual meeting of the House of Delegates.

Proposed constitutional amendment

Introduced by Marcia Richards, MD, at the 1993 House of Delegates

To rescind the 1989 amendment of Article VI which capped the Board to no more than 31 elected district directors and reinstate the Article VI language then in effect prior to that amendment except that the calculation would be made with 215 (instead of 200) and the calculation shall occur no more often than every 5 years, the articles would need to be amended as follows:

Article VI Board of Directors

There shall be elected one director from each district~~.~~, except that in any district with 215 or more regular and special members, there shall be elected one additional director for each additional 215 members or majority fraction thereof. This calculation shall be made no more often than once every five years. ~~In addition, there shall be elected director(s) from each district based on a formula using the number of members in each district as the numerator and the total membership of the Society as the denominator, rounded to the nearest whole number. This calculation shall be made every third year, and, as nearly as possible, is to provide for no more than 31 district directors and shall be based on the year end totals. The number of directors established for each district shall be approved by the Board and shall be reported to the districts by the secretary before annual elections to the Board.~~ As nearly as possible, one-third of the members of the Board shall be elected each year. ❖

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Physician briefs

Anita Arnold, MD*, of Whitefish Bay, has joined the staff of Milwaukee Cardiology Associates. Dr Arnold serves on the advisory board of women's health services at St Luke's Health Center in Milwaukee.

Brian Brotz, MD*, and Lars Ostman, MD*, have joined the medical staff at St Agnes Hospital in Fond du Lac. Both anesthesiologists are affiliated with Anesthesia Associates Ltd. Dr Brotz received his medical degree from the University of Wisconsin Medical School in 1985. Dr Ostman earned his medical degree in 1981 from the Helsinki (Finland) University Medical School.

James V. Bruno, MD*, Douglas L. Carlson, MD*, and Shelly K. Waters, MD*, have joined the staff of Wilkinson Medical Clinics, Medical Specialists of Hartland and Memorial Hospital of Oconomowoc. Dr Bruno specializes in orthopedics and is board certified in orthopedic surgery. He graduated with honors from the University of Wisconsin Medical School and completed residency work at State University of New York at Syracuse. Recently, he was affiliated with St Michael Hospital in Milwaukee. Dr Carlson specializes in obstetrics and gynecology. He graduated from UW Medical School and interned at the United States Naval Hospital in Oakland, Calif. After completing a residency at St Joseph's Hospital in Milwaukee, he practiced medicine in New Hampshire. Dr Watters specializes in internal medicine. She graduated with honors from the Medical College of Wisconsin and completed an internship and residency there in 1991.

Edmund Duthie, Jr, MD*, professor of medicine and chief of geriatrics/gerontology at the Medical College of Wisconsin, Wauwatosa, was honored with the Milo D. Leavitt Memorial Award at the annual meeting of the American Geriatrics Society. Dr Duthie is chief of the nursing home care unit at the Veterans Affairs Medical Center-Milwaukee, director of geriatrics at Froedert Memorial Lutheran Hospital and a staff physician at the Milwaukee County Medical Complex.

Burnell Eckhardt, MD, of Sheboygan, has been elected to a four-year term on the Lakeland College Board of Trustees. Dr Eckhardt is a graduate of the University of Wisconsin Medical School. He is a retired internist.

Terry L. Gueldner, MD*, has been appointed to serve on the Board of Directors for the Wisconsin Chapter of the American College of Surgeons. His term will run through 1996. Dr Gueldner is associated with the Manitowoc Surgical Association, SC and is on the staff of Holy Family Memorial Medical Center and Two Rivers Community Hospital.

Cheryl Huber, MD*, has joined the medical staff of St Michael Hospital in Milwaukee. Dr Huber received her medical degree from the University of South Carolina in 1980. She completed her internship and psychiatry residency at the Medical College of Wisconsin.

Joseph R. Lamb, MD*, has joined La Salle Clinic in Clintonville. Dr Lamb will provide complete family health care, including ob-gyn serv-

Deadline nears for Physician-Citizen of the Year award nominations

THE DEADLINE IS fast approaching for the 1994 Physician-Citizen of the Year award. Recipients are recognized for the civic, cultural, economic, charitable and health care services they have provided to their communities or the state. Nominees must be Wisconsin residents, with either an M.D. or a D.O.

The Physician-Citizen of the Year award is presented annually based on nominations from Wisconsin residents. Except in unusual circumstances, the community service for which the physician is being honored should be uncompensated. Preference is given to current service over lifetime service. Previous winners are not eligible. The deadline for nominations is Feb. 14.

To nominate a physician, send his or her name, address and a description of the activities you believe to be outstanding to *Medigram*, State Medical Society of Wisconsin, P.O. Box 1109, Madison, WI 53701. Please include your name, address and telephone number with the nomination.

Questions? Call Lynne Bjorgo, Shari Hamilton or Russ King at the SMS, 1-800-362-9080.◆

ices. Dr Lamb completed his residency at Waukesha Family Practice Residency and is board certified. He is a graduate of the Medical College of Wisconsin.

Laurie Logan, MD*, has joined the Family Practice Clinic of Sparta. Dr Logan is a graduate of the University of Illinois medical school. She recently completed a family practice residency at Brown University in Rhode Island, where she was chief resident in 1992-93.

William O. Myers, MD*, has been awarded the Gwen Sebold Research Fellowship. Dr Myers, a Marshfield Clinic cardiovascular and thoracic surgeon, is a 25-year veteran of the Marshfield Clinic staff. He has chaired the Foundation's Research Committee for eight years, has published 112 papers and invented two vascular operations. He received the $5,000 fellowship award for his work on coronary artery surgery.

Bryan Schmitt, MD*, and Jill I. Schmitt, MD*, have joined the staff of the Sheboygan Clinic. Both specialists in internal medicine, they graduated from the University of Wisconsin Medical School then completed their internships at the University of Connecticut in Farmington and residencies with the Marshfield Clinic.

Nathan Smithberg, MD*, an emergency physician, has joined the Midelfort Clinic in Eau Claire. Dr Smithberg received his medical degree from the University of Minnesota medical school in Minneapolis and completed his residency in internal medicine at Marshfield Clinic and St Joseph's Hospital in Marshfield. Most recently he served as medical director of emergency services at St Joseph's Hospital in Chippewa Falls.

Lisa Ramsay, MD*, has joined the staff of the internal medicine department at Kurten Medical Group in Racine. Dr Ramsay is a graduate of the University of Wisconsin Medical School and was with the University of Pittsburgh Health System-Presbyterian University Hospital for her internship and residency.

Joseph W. Rucker, Jr., MD, has joined the outpatient clinic staff of Bloomer Community Memorial Hospital. He is a plastic surgeon. Dr

Continued on next page

PHYSICIANS

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Continued from preceding page
Rucker completed his medical training at the Michigan State University College of Human Medicine in East Lansing. His postgraduate training in general surgery was done at Mount Carmel Mercy Hospital in Detroit, followed by training in plastic and reconstructive surgery at Wayne State University in Detroit and the Atlanta Plastic Surgery Clinic in Georgia. He is board certified.

Raymond C. Zastrow, MD*, of Hartland, has been elected president-elect of the College of American Pathologists. Dr Zastrow, a member of the SMS Board of Directors, has served as the CAP secretary-treasurer, a member of the board of governors and has chaired a number of CAP committees and commissions. A clinical professor of pathology for the Medical College of Wisconsin, Dr Zastrow earned his medical degree from Marquette University.◆

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Solutions to the puzzle on page 28

CONSULTING CONTRACTS - MADISON. The Wisconsin Disability Determination Bureau has a contract open for a Board Certified Pediatrician to work 10-25 hours per week in a central Madison office location. Hours and schedules are flexible. Work is with the review of medical and other records for the evaluation of Supplemental Security Income Disability claims. No patient contact is involved. Resumes will also be accepted for potential future openings in other medical specialties or psychology, although no current vacancies are available. For further details contact: James Twist, Section Chief, Disability Determination Bureau, Department of Health and Social Services, P.O. Box 7886, Madison, WI 53707-7886. (telephone 608-266-3996) 1-2/94

CHICAGO: NORTHERN SUBURBS - Several members of the medical staff of Condell Medical Center are seeking associates for opportunities in **family practice, internal medicine, pediatrics and OB/GYN.** Condell is a progressive community hospital centrally located in the rapidly expanding far northern suburbs of Chicago. Our growing service area features all the amenities of family oriented suburban living, including award winning school systems, with easy access to Chicago. Complementing the hospital's main complex are a full service health club, intergenerational day care center, and a conference center. For information, contact Susan Kilpatrick, Physician Outreach at (708)362-2905, ext. 5280 or fax materials to (708)362-1721. 1-3/94

OSHKOSH, WISCONSIN - Medical groups are recruiting in Family Practice, Pediatrics, Pulmonology, Orthopedic Surgery, Emergency Medicine, and Otolaryngology. Mercy Medical Center has an active medical staff of 130 physicians in all medical specialties. Oshkosh is an attractive community of 55,000 people, located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley (metro area of 350,000 people). University of 12,000 students. Competitive financial packages. Contact Christopher Kashnig; Mercy Medical Center; 631 Hazel Street; Oshkosh, WI 54902. Call 414-236-2430. Fax 414-236-1312. 1-2/94

MEDICAL DIRECTOR — University of Wisconsin-Whitewater. Medical Director (MD) position available in college health to provide direct care, supervision of clinical staff, and share medical expertise with the university community. Prefer BE/BC FP, IM, or PED. No weekend or call. Applications should be submitted immediately and will be accepted until position is filled. Call Ruth Swisher at (414) 472-5600. FAX: (414) 472-5608. Equal opportunity employer. 12/93-1/94

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Physicians Exchange

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Physicians Exchange

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9/93;TFN

WISCONSIN: Family practitioner needed by a growing practice of a four physician group in a friendly rural community in Northeast Wisconsin near Green Bay. This is an excellent opportunity to join an established organization. Highly competitive salary with benefits. Please contact: Artwich Clinic, Oconto Falls, Wisconsin 54154. 9/93-4/94

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12/93-3/94

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Practice for Sale: East side Milwaukee physician desires to sell his primary care-family practice, near hospital. Good patient mix. Great opportunity for dynamic person to purchase goodwill, patient records, medical equipment. Contact: Barton-Collins, Ltd., c/o Dan Collins, 9401 West Beloit Road, Suite #312, Milwaukee, WI 53227; ph 414-541-6099. 1-3/94

For Sale

Continued

FOR SALE: Kodak DT-60 Analyzer purchased new 12-1-92. Never used for patient testing due to consolidation of 2 clinic labs. For more info call 608-348-4677 or write to PO Box 659, Platteville, WI 53818. 12/93-1/94

Medical Meetings-Continuing Medical Education

Primary Care Update
Utilization and Application of Cardiology
February 25 & 26, 1994

Course Directors:
Dr. M. Wasiullah, Dr. J. Leibsohn, Dr. M. Becker

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In addition, there will be workshops to insure good application of various diagnostic procedures - EKG, chest X-ray, stress testing, imaging. Included in this course registration is daily continental breakfast, lunch (with guest speaker) on Friday, and CME credit. Based on the meeting format we have applied for 16 hours of AAFP credit. Price: $50/physician; $25/resident/intern.

For further information call 414-481-8400. 11-12/94-1-2/94

Medical Meetings-Continuing Medical Education

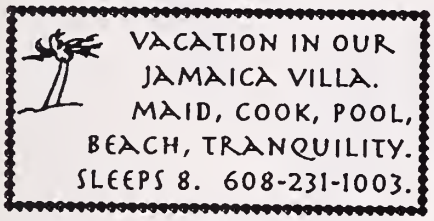
Continued

18th Annual Winter Pediatric Seminar, February 10-11, 1994, Indianhead Resort, Wakefield, Michigan. Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449. 1-800-541-2895.
12/93-1/94

AMA

June 12-16, 1994: Annual AMA House of Delegates, Chicago.
December 4-7, 1994: Interim House of Delegates, Honolulu.

Miscellaneous



THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

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There are no small victories in the fight against heart disease.

American Heart Association

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State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS - 1994-1995

The 1994 meeting will be in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the Hyatt Regency as the headquarters hotel.

1994 - April 13-16: Milwaukee

1995 - April 5-8: Milwaukee

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free: 1-800-362-9080.

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Simply, *Health Access America* proposes health insurance coverage for all Americans, regardless of income or health status. It calls for expanded publicly-funded health care for the needy; a stronger Medicare system; employer-provided coverage for all workers and their families with tax incentives for small businesses.

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To get a copy of the *Health Access America* proposal, please call our Member Service Center at 1-800-AMA-3211.

The American Medical Association

on behalf of member physicians and their patients.

A message from The American Medical Association for the Health Access America Proposal

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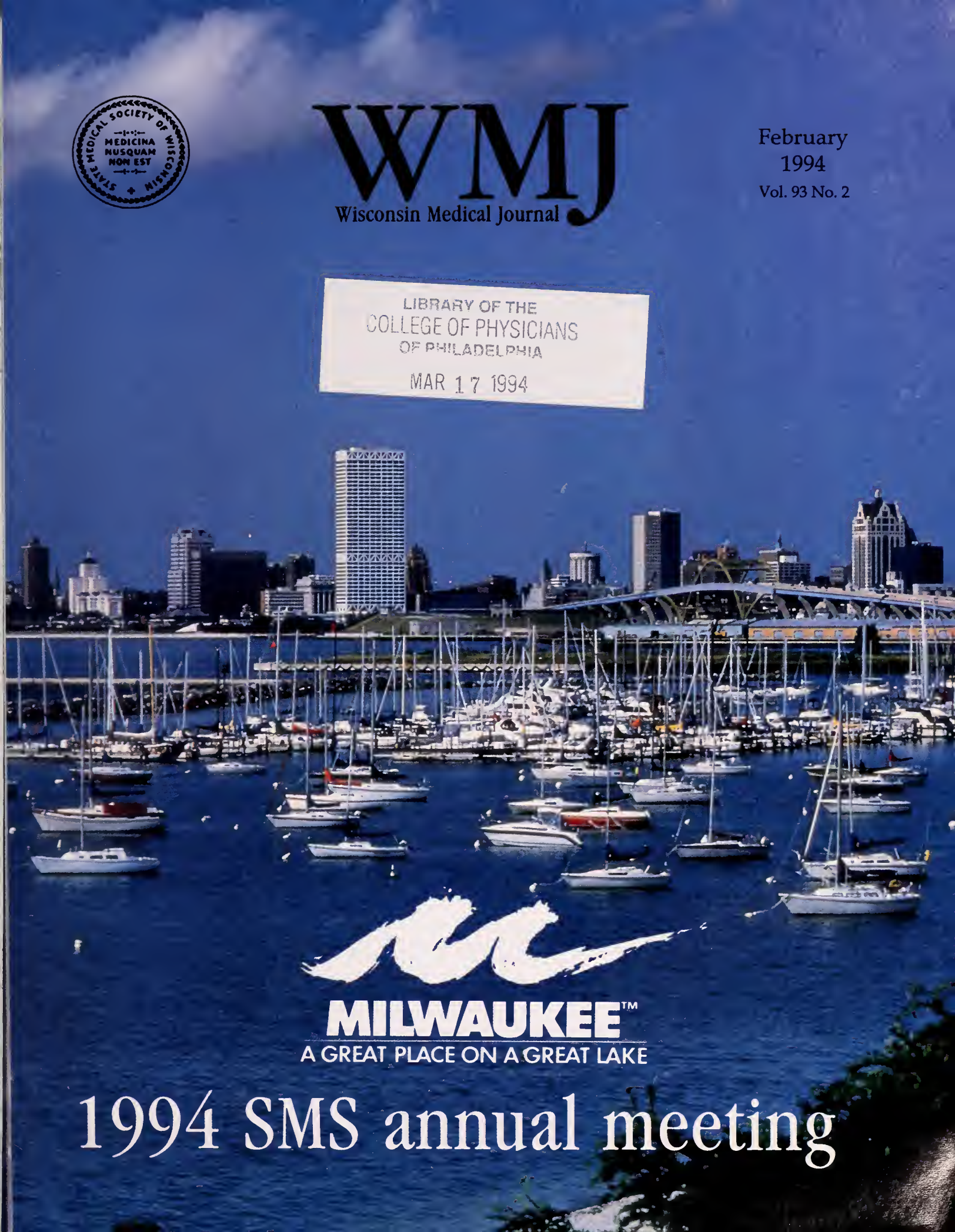

1994 SMS annual meeting

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Contents

February 1994 Vol. 93 No. 2

Opinions

43 *President's page*
Physicians remain vital to the war on tobacco
by Pauline M. Jackson, MD, La Crosse
44 *EVP report: The view from here*
The value of a Wisconsin physician defense "association"
by Thomas L. Adams, CAE, Madison
48 *Letters*
WIPRO petition draws fire
by George L. Gay, MD, Cambridge
50 Food for thought
by Vinoo Cameron, MD

Scientific

51 DNA testing and genetic counseling: truth or consequences
by Norman C. Reynolds, MD; Robert R. Lebel, MD; Kerry de S. Hamsher, PhD; Barry Blackwell, MD; B. Rafael Elejalde, MD; and Gregory R. Winter, MD; Milwaukee, Brown Deer, and Elmhurst, Ill
55 Outcomes of resuscitative efforts at Wild Rose Hospital
by Dan H. Fifield, MD, Wild Rose
58 LEEP: Early experience with a new approach to cervical lesions
by Jerome H. Gundersen, MD, and Sheila Nichols, La Crosse

Socioeconomic

63 *Public health*
Asthma hospitalizations in Wisconsin: public health implications
by Jay Goldring PhD; Lawrence Hanrahan PhD MS; and Henry Anderson, MD; Madison
68 Wisconsin physician named to national health post
69 The use of practice guidelines in Wisconsin for liability protection
72 Medical Examining Board elects officers
74 Business seminar scheduled for Wisconsin physicians

Organizational

77 Nominees for SMS offices: 1994-1995
80 Survey to determine interest in SMS electronic bulletin board system
80 SMS annual meeting program on domestic violence
81 *Book review*
The Life and Times of a Country Doctor
by Shari Hamilton, assistant editor
82 Physician briefs
83 Ulmer, Newcomer to serve on AMA advisory committee
84 County society news
85 SMS commission to sponsor program on medical liability
86 Medical student program sponsors sought
87 New guidelines on HIV, nicotine released
87 Racine, Milwaukee, and Rock counties hold mini-internships
88 Obituaries

Our cover: The 1994 annual meeting is in Milwaukee. A tear-out section of this *WMJ* is your program.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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President's page

Physicians remain vital to the war on tobacco

IN SPITE OF the tobacco industry's continuing barrage of advertising propaganda and financial pressures on businesses and politicians, cigarette use (synonym for body abuse) is declining in many areas. We see this in: Wisconsin restaurants going smoke-free or reducing their smoking areas to unappetizing back corners; the rapid increase in numbers of smoke-free businesses; and cities working on ordinances to further limit areas for smoking and make it more difficult for youth to obtain tobacco materials. Many fast-food restaurants have acknowledged the fallacy of promoting eating areas for children in smoke-polluted environments and are doing something about it.

We have a large number of people to thank for this, including Wisconsin's Project ASSIST, the Tobacco-Free Wisconsin Coalition, local tobacco-free coalitions and the Wisconsin Initiative on Smoking and Health, among others.

I especially applaud all those physicians who have made the question of smoking and how to stop (or not start) a routine part of as many patient encounters as possible. This type of intervention has an estimated 20% success rate--not bad for the very difficult addiction.

I recommend as our continuing education in this area the Feb 23 issue of *JAMA*, which is devoted to tobacco problems. Included are: a 50-year study on the effects of tobacco advertising targeted toward teenage girls; a report on the effects of secondhand smoke on pregnant women and their babies; more on targeting cigarette sales to children, minorities and the poor; and a review of what works in successful smoking cessation programs.

The surgeon general's report on tobacco, to be released Feb 24, will also be of interest to us all.

The AMA guidelines for tobacco intervention--which many of you have received--point out that 419,000 Americans die annually as a result of tobacco use (8,760 Wisconsinites). Environmental tobacco smoke accounts for many more. The AMA and the American Cancer Institute suggest five "A's" for intervention:

- ask--smoking history;
- advise--reasons to stop;
- assist--with motivational and self-help materials, a "quit" date, and a plan tailored to each patient;
- arrange--follow-up visits or telephone calls; and
- anticipate--with prevention strategy for teenage and child non-smokers. This is the most important area of intervention we have.

Pauline M. Jackson, MD

Watch for the Kids at the Capitol program, sponsored by the Tobacco-Free Wisconsin Coalition, March 16, when school children from the SmokeFree Class of 2000 will be lobbying in Madison.

Meanwhile, the SMS continues to work for increased cigarette taxes, primarily to decrease the numbers of new smokers and to reduce access to cigarette purchase by teenagers and children. We must not forget the dangers of smokeless tobacco as well. The task to eliminate tobacco use is far from finished and the role of physicians remains paramount.❖

SMS annual meeting

April 13-16, 1994

Milwaukee

EVP report: The view from here
The value of a Wisconsin physician defense "association"

An Associated Press story recently on the wires caught my eye, because it was on the startling differences between American and Canadian malpractice insurance. Richard Shekter, a Toronto lawyer and expert in health law was quoted as summing it up this way: "The United States is a system out of control."

But then, we knew that. In case there is any doubt, consider some of the numbers presented in the story. In Canada, the lowest rate of what we would call malpractice premiums is about $1,100 for a family practitioner doing no obstetrics or surgery; that same doctor in the lowest-rate state in the United States would pay about $2,800. A neurosurgeon in Toronto pays a premium of $12,700; in Wisconsin, it would be $47,000. A physician practicing family medicine, including delivering babies, in Toronto reported paying $2,322 a year for malpractice protection; in Wisconsin that doctor would be paying as much as $26,000.

It is a bit ironic that with so many people looking to Canada as a model for our own health system reform that the one area in which the Canadian system is clearly superior has gone virtually unnoticed. In Canada, protection against malpractice claims isn't technically insurance, but a mutual defense organization, which was founded in 1901 and to which 90% of Canada's doctors belong. The doctors pay an annual fee to belong to the organization, and that organization maintains a reserve from which physicians can be helped as needed.

Quoting from the AP story:

Unlike American insurers that impose limits, most frequently $1 million per claim and a $3 million maximum, the (Canadian Medical Protective Association) sets no limits. Nor does it settle cases out of court just to get rid of them. That tells plaintiffs that, when they tangle with doctors in Canada, they will have a fight on their hands.

The good news is that physicians have, at least here in Wisconsin, an organization that looks and operates quite a bit like the Canadian Medical Protective Association: It's called the Physicians' Insurance Company of Wisconsin. No, this is not a sales pitch, not an "advertorial." This is a perspective on PIC Wisconsin that we don't often appreciate as we should.

Consider that, last year, PIC spent $5.7 million defending physicians against malpractice claims and paid only $5.2 million in settlements. So what? The average defense-to-settlement ratio for American medical liability companies is 1:2. That's right, other insurance companies pay off twice as much as they put into defense. What we have in PIC is a powerful and aggressive ally that turns the tables on those who "tangle with doctors" in this state. If the numbers don't convince you, just listen to what leaders in the legal profession are saying around the state--PIC's resolve to fight for its physicians has curtailed the penchant of some to sue with less than just cause. Like the Canadian defense association, PIC refuses to pay off claims just to make them go away (since 1987, PIC has closed 86% of its claims without payment).

Consider, too, that PIC is organized in much the same fashion as the Canadian Medical Defense Association, because it is physician-owned.

Continued on page 46

Thomas L. Adams, CAE

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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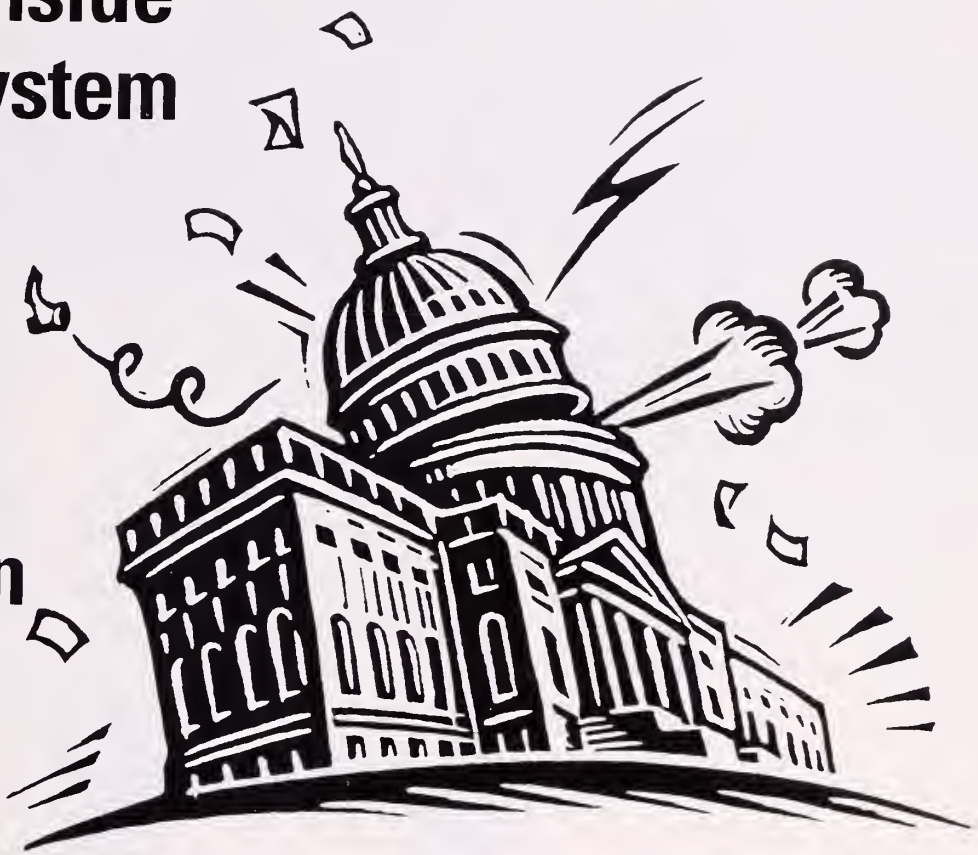

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The American Medical Association will host an interactive meeting of key congressional policy makers and physicians from across the country. *Partnership in Action: Uniting for America's Health* takes place March 8 in Washington, DC.

March 8 will be a day filled with interactive dialogue between policy makers and the physicians who will be affected by those policies. Dinners will feature roundtable discussions with congressional members from coast to coast.

Your presence at the 1994 summit can make a difference. To register now, call 800 262-3211.

American Medical Association

Physicians dedicated to the health of America

Continued from page 44
Canadian doctors may call it a "membership fee" while Wisconsin doctors call it a "premium," but in function there is little difference. In both cases, physicians have the comfort and satisfaction of knowing that the organization defending them holds their best interests as top priority--not the interests of nameless, faceless, non-physician stockholders who seek only ever greater profits.

As a member of the PIC board of directors, I see my role chiefly as a physician advocate. And in that role, my primary goals are to achieve stability in both the availability of coverage and the rates charged for that coverage. The volatility of liability insurance during the 1970s and 1980s demonstrated just how important these goals are. Many saw premiums increase by outrageous amounts, some found it almost impossible to find coverage at any price, and some were abandoned when their liability insurance companies withdrew from the market. One small Wisconsin clinic was dropped with only 30 days' warning in 1987--after being a customer of the insurance company for more than 30 years! Not only was the clinic left scrambling for insurance, it was delivered the crushing financial blow of a $200,000-plus bill for tail premiums.

The unreliability of these carriers was the primary motivator in the creation of PIC Wisconsin. The 1980 House of Delegates directed the SMS to investigate the feasibility of a physician-owned liability insurance company. In 1986, the House of Delegates unanimously voted to authorize the establishment of PIC Wisconsin, a wholly physician-owned company. With a great deal of work over the next few months, PIC was pulled together and wrote its first policy on Nov 1. By the end of the year, PIC was insuring 1,600 Wisconsin physicians. The past several years have seen PIC encounter and respond positively to new government regulations, new management operations and changes in the market. Today, more than 4,000 Wisconsin physicians--roughly 60% of the state's licensed, practicing physicians--have PIC as their "defense association."

Now, some of the insurance companies that deserted Wisconsin's physicians when the going got tough a few years ago have had the temerity to re-enter the market. There are also some new companies entering Wisconsin, trying to take advantage of a market that is currently "soft." Can Wisconsin physicians trust them, or will they be abandoned again when the market changes, as surely it will.

One measure of reliability is the rate charged for premiums. Sure, no one wants to spend more for insurance than they have to, but cut-rate premiums can be taken as a sign of fiscal irresponsibility. Although the calculations of insurance rates by actuaries is a black-and-white matter of putting data into formulas and producing numbers, the development of insurance rates is grayed when the numbers and assumptions about those numbers are put together before the calculations are completed.

The assumptions that must be made are about variable numbers

Continued on page 48

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

* Andrew, Mark H.
* Bamrah, Paramjit K.
* Billings, Kenneth J.
* Bodemer, Steven E.
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* Chelius, Carl J.
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* Samadani, Ayaz Mahmud
* Schneider, George R.
* Schultz, Richard O.
* Seno, Louis S.
* Shapiro, James A.
* Short, Howard W.
* Stafl, Jaroslava
* Stenzel, Steven D.
* Strimling, Arnold M.
* Trader, Joseph E.
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*Based on I.R.S. guidelines. **Date effective 12/1/93. Subject to change.

Continued from page 46
regarding factors such as current losses, projected losses from legislative changes, losses projected from historical factors, loss severity and trends, company general expense, loss-allocated expense, and taxes. The insurance company must select numbers for each of these factors and plug them into the rate formula.

To stay financially sound, a company will make certain that aggressive numbers are not picked for several of these variables. For example, if the numbers for projected losses, loss severity or expenses are too low, the rate produced by the formula will be inadequate to cover actual losses, and the company will be financially unsound. By the same token, it is important that the company not take an overly conservative approach for other "gray" variables.

My point here is not to expose you the wonderful world of actuarial tables, but to emphasize how the assumptions made--before the numbers are crunched--can change the final rate, and how those assumptions and rates can reflect the stability of an insurance company.

The bottom line is this: You may be approached by companies offering lower premiums than those currently offered by PIC Wisconsin, but you will never be approached by a company demonstrating greater allegiance to Wisconsin's physicians. The choice will be yours. Do you, in an era in which the "system is out of control," want merely the cheapest premium you can find, or do you want a stable, dedicated, responsible advocate that is aggressive in your defense and is owned by you and your peers? Some answers are easier than others. ◆

Letters
WIPRO petition draws fire

To the editor: I read with dismay in the December *WMJ*, Dr Murdock's cheap shots at WIPRO....

(T)he secrets to successfully avoiding the WIPRO threat are: practice good medicine and document that practice. Failing one or both of the first two secrets, you may receive an "Initial letter of potential sanction" from WIPRO and need the third secret: ... carefully reread the chart as though you knew nothing about your patient, or your practice. Try to understand how someone reading only the chart might ask the question outlined in the letter you received.

If you find missing documentation of information you thought unimportant at the time of the patients' hospitalization that explains the questions raised, write an addendum to the chart and send WIPRO a copy.... If you discover (for example) that you forgot to order a follow-up EKG on a patient admitted with chest pain, explain ... and ask to discuss the case with a WIPRO physician. Chances are good that a peer physician will understand your reasons and help you create a convincing reply to the letter.

If you choose instead to attack WIPRO .... HCFA requires WIPRO to give you an opportunity to discuss, face-to-face, your care of this patient. If your discussion is unconvincing, this panel ... is obligated to offer you an opportunity to participate in a ... "corrective action plan" (which) might permit you to provide evidence of successful comple-

Continued on page 50

The only horticultural structure of its kind in the world the Mitchell Park Conservatory in Milwaukee known as the Domes, features tropical, arid and seasonal displays. The SMS annual meeting program is in this issue of WMJ.

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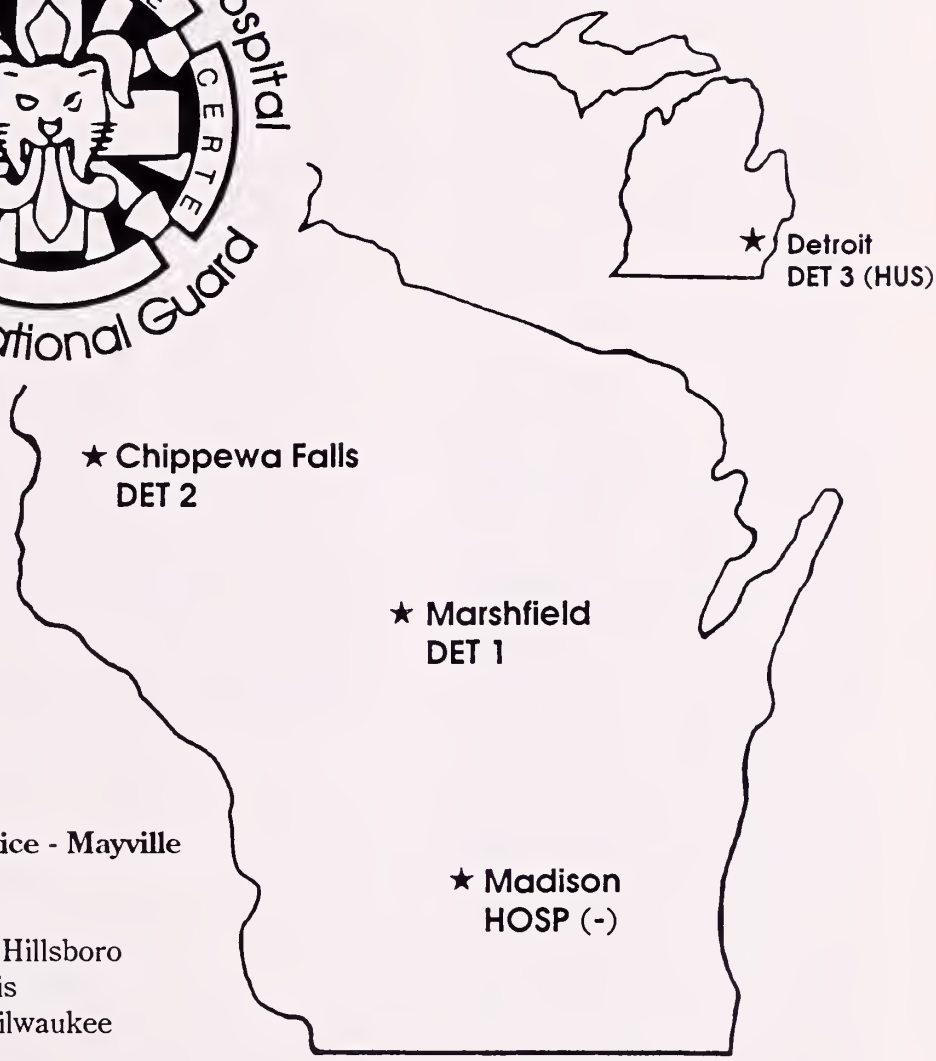

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Presentations to Medical Groups Available

Continued from page 48
tion of an education conference ... as an indication of your willingness and ability to improve your care of patients.... If you refuse to participate in a CAP, or if you completed a CAP for the same problem last year and continue to mismanage (the same condition) then WIPRO is obligated to recommend to HCFA that you be considered for sanction.

HCFA then reviews everything, and you have yet another opportunity to present your case ... before sanction is imposed. This lengthy process explains why fewer than one physician per year achieves sanction status....

WIPRO is changing.... The onerous and petty point system has disappeared. HCFA has reduced the number of records reviewed by 80%. HCFA now requires PROs to work with hospitals and physicians to exchange data and analyze procedures and practice patterns to improve patient care and cost effectiveness. The reduced record review workload is allowing WIPRO to use its internal quality assurance program to eliminate problem physician reviewers.

...Few states have a physician dominated PRO with the national reputation enjoyed by WIPRO. Would you really rather have the insurance industry or some other non-physician consumer group reviewing your medical care?...

No, WIPRO is not the best we can do. We can do better, if (we) facilitate the work our colleagues are doing in WIPRO to improve medical care. The next few years will see more changes in health care than any of us ever imagined. WIPRO will need lost of physician help to interpret the rapidly changing federal guidelines in ways that are meaningful and relevant to our practices. If Dr Murdock had circulated a nominating petition for the WIPRO board ... he could now be effecting very significant reforms, as a new member of the board. Think about it.

--George L. Gay, MD
Cambridge

Editor's note: This letter was edited for length.✦

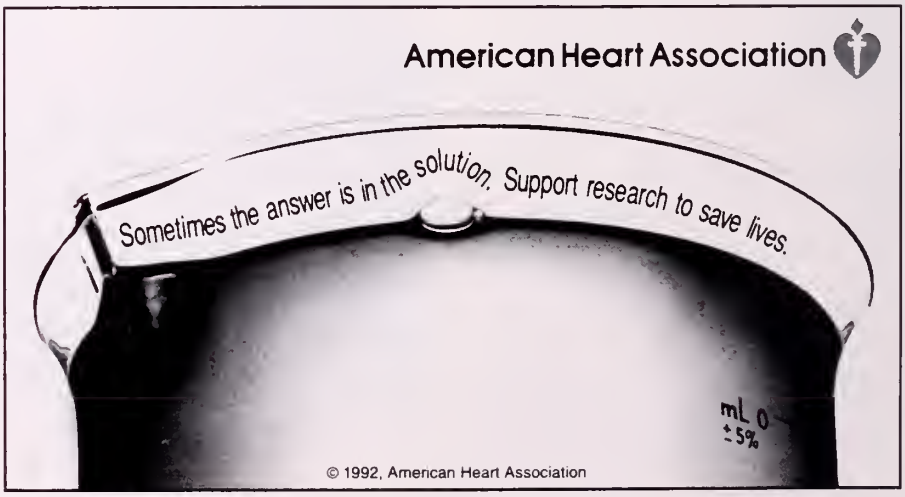
Food for thought

To the editor: I'm writing this letter to stimulate thought and possible encourage response from other society members as to standards that would generally apply in these situations.

I had a patient here recently who had sustained an amputation of the distal portion of his finger. After the amputation was revised, patient insisted that he would like to have that finger which he brought along. I asked him why and he said, "Well, he would like to make a necklace out of it after he had dried it." I told him it was unethical for us to dispose of human organs like that, plus there may be health requirements for clinics to dispose of tissue. This gentleman replied that his buddy had a lung tumor removed and carried in his possession his lung and tumor and was known to have showed it around to his buddies. I was astounded to find out that this story was correct and additionally I now hear from some patients that some place in Canada women are allowed to take possession of their fetuses after abortion.

I happen to believe that the practice of medicine, no matter how much it advances, is still limited by basic ethics which will never change. I would appreciate other physicians' comments in this regard.

--Vinoo Cameron, MD
(city withheld on request)✦



DNA testing and genetic counseling: truth or consequences

Norman C. Reynolds, MD; Robert R. Lebel, MD; Kerry de S. Hamsher, PhD; Barry Blackwell, MD; B. Rafael Elejalde, MD; and Gregory R. Winter, MD; Milwaukee, Brown Deer, and Elmhurst, Ill.

Advances in medical genetics are providing a major clinical challenge to practitioners seeing patients concerned about their risk of developing either inherited disease or susceptibility to acquired disease. Popular information can easily exceed our professional ability to provide services to well-read patients who want answers with scientific certainty. The challenge also involves ethical questions regarding confidentiality and the way that results are disclosed. More often than not, the test itself becomes the focus of psychosocial expectations for the future and lifestyle of the patient and family. The behavioral consequences of disclosure of test results need to be anticipated by the caregiver to avoid adverse psychological outcomes. *Wis Med J.1994;93(2):51-54.*

The rapidly expanding knowledge of increasingly specific and predictive genetic information relative to health and disease has become staggering in its pace. New major journals have sprung into existence to accommodate the information explosion in this field.

In 1992 alone, the first volumes for *Human Mutation, Nature Genetics, Human Molecular Genetics,* and *Journal of Genetic Counseling* were published. In 1993, the *American Journal of Medical Genetics* not only expanded to 20 issues per year, but added yet another four issues devoted entirely to genetic advances in neuropsychiatry.

Specific abnormal genes, or DNA lesions, causing major hereditary disease are becoming known with increasing frequency. In 1989, the gene responsible for cystic fibrosis was discovered[1]; yet it was soon appreciated that while the mutation causing 70% of abnormal alleles is easily detected by DNA testing, the remaining 30% of abnormals are accounted for by hundreds of other mutations most of which are quite rare.[2] The example of cystic fibrosis destroyed the myth of simple genetic inheritance of one mutation producing one trait. Although this was exciting as a first example of multiple different genetic versions of what on the surface appears as a single disorder, it leaves us with several difficulties in the identification of abnormal gene carriers, ethical issues in population screening, and residual scientific uncertainty for patients wanting to make personal decisions.

Since then, investigators have identified genetic lesions responsible for myotonic dystrophy,[3] muscular dystrophy,[4] facioscapulohumeral dystrophy,[5] fragile X syndrome of mental retardation,[6] Huntington's disease (HD),[7] and others. The implications for prediction of the future onset of symptoms, for prenatal diagnosis, and for interference in the natural processes of genetic transmission from one generation to another are impressive.

Yet they are not the whole story: We must also consider the possibility of gene replacement for definitive genetic therapy, and the potential for the invasion of privacy at a level of intimacy which we have only just begun to imagine.

The novel and film versions of Michael Creighton's *Jurassic Park* are intended both as fantasy of scientific potential and as stern warning of pitfalls inherent in genetic engineering. Although it appears foolish, one of the authors has been approached regarding the feasibility

From the Wisconsin-Illinois Huntington's Disease Study Group. Reprint requests to: Norman C. Reynolds, Jr., MD, Neurology Service (127), VA Medical Center, 5000 W Wisconsin Ave, Milwaukee, WI 53295. Copyright 1994 by the State Medical Society of Wisconsin.

of reconstructing a deceased loved one from a DNA extract.

Amid all this, the human genome project, which has set as its goal the complete mapping of the human genome in the next decade, includes millions of dollars allocated to education and to exploration of legal and ethical implications of the work being done at dizzying speed in hundreds of laboratories around the world. One of us is participating in a study, supported by this genome project through the National Institutes of Health, designed to educate primary care physicians on the accomplishments and implications of this work.

For several years, our group has been intimately involved in the application of presymptomatic genetic testing to one of the more challenging of the inherited diseases: HD (chorea major). Our experience in this work leads us to offer this discussion to provide examples of the kinds of issues that need to be addressed in genetic testing.

Huntington's disease

Our testing procedure is interdisciplinary and based on the national protocol for genetic testing of the Huntington's Disease Society of America. Independent examinations are provided by a neurologist, a neuropsychologist, one of two psychiatrists, and one of two medical geneticists. One of the medical geneticists performs both direct DNA testing and linkage analysis for HD locally in his laboratory.

The format for the interdisciplinary team approach has grown out of the original series of linkage testing families used by Gusella and others (1983) to define the genetic location, initially found on the short arm of chromosome 4, distal to the centromere. Subsequently the actual gene, IT15, has been identified and contains an abnormally large number of a sequence of three repeating nucleotides, CAG.[7] In the earlier studies, participants were not told the results of the linkage analysis. There was both a fear of negative behavioral response and concerns about confidentiality.

(CAG represents cytosine-adenine-guanine in the nucleotide base sequence of DNA. This triplet typically codes for the amino acid glutamine in subsequent protein synthesis, but in this case may represent some form of punctuation in the process of transcribing the DNA into messenger RNA which controls the protein synthesis.)

Prior to the use of direct DNA testing, which measures the number of CAG repetitions, pre-symptomatic testing for HD defined a probability of inheritance based on a linkage analysis of markers near the presumed site of the HD gene, with the necessary involvement of several family members providing blood or other tissue samples. The psychological investment in specific anticipated outcomes has been remarkably varied. The degree of personal commitment to the testing process is especially enhanced because the participants have witnessed the ravages of HD in relatives deteriorating in coordination, speech, emotions, and intellect. This is heightened by the realization that the risk of inheritance is 50% and penetrance is 100% (generations are not skipped). In addition, the majority of patients already had children of their own.

After several early studies of psychological outcome showed favorable results with a team approach, those of us able to perform such tests developed more confidence in the interdisciplinary protocol and its ability to avoid unnecessary emotional upheaval. Each member of the team provides education and support to the test candidates, who are typically ambivalent about learning of their future. Except for the genetic test per se, confidentiality is maintained by guarding the pivotal diagnosis and using symptomatic complaints as the basis of clinical interaction (ie, headaches, insomnia, malaise).

The unique roles of the team practitioners are complementary. The neurologist reviews the family history to document the presence of HD and examines and defines the patient as symptomatic or asymptomatic. If the patient shows signs of morbidity, a differential diagnosis is pursued and relevant tests are ordered.

The neuropsychologist performs extensive testing of the patient, searching for organic pathology and personality features of interest to the psychiatrist. The psychiatrist determines the degree of commitment of the patient to the testing process and helps the patient anticipate the behavioral consequences of a negative, positive, or indeterminate test result.

The medical geneticist gathers complete family history, arranges for the acquisition of blood and tissue samples, reviews ethical and legal aspects of potential results, performs the actual test, and informs the patient of the results.

Two other participants are required prior to disclosure. One is a

Reasons for wanting to know the risk of having Huntington's disease.

- Prior to vocational change or educational commitment.
- Prior to wedding or divorce.
- Uncertainty causes anxiety, decreases work efficiency.
- Pre-symptomatic parent wants to counsel children on their risk as they anticipate marriage or having children.
- Parent wants rebellious adolescent tested to explain behavior.
- Individual secretly planning suicide.
- Approaching death from another disease, anxious to know HD status before dying.

local counselor chosen by the patient and briefed by the psychiatrist. The other is a trusted confidant (usually a spouse), who accompanies the patient at the disclosure meeting.

Our protocol is open regarding the order of evaluation and allows outside practitioners to provide certain segments of the evaluation, due to constraints of a managed care system, personal preference, or geography. In some cases a local counselor may perform the disclosure.

Team evaluations

Diagnostic alternatives uncovered in the assessment process of patients with a positive family history have included depression, Lyme disease, Wilson's disease, systemic lupus, somatization disorder, anxiety disorder, adult-onset Pelizaeus-Merzbacher disease (Lowenberg-Hill subtype), essential tremor, and HD. When a treatable alternative to HD is uncovered, it is not unusual for the patient to defer or even to lose interest in the genetic testing process.

When clinical HD is suspected prior to linkage analysis but the physical findings are borderline or subtle (ie, rare facial tic, minimal chorea) a technicium (Ceretec) SPECT scan can help confirm the diagnosis by showing selective hypoperfusion of caudate nuclei. In fact, because astrocytes are metabolically active and proliferating as neurons in the caudate deteriorate, structural scans (CT, MRI) and metabolic scans (PET) are often normal in appearance until the patient enters a later stage of clinical HD.

During behavioral interviews patient incentives to establish the risk of developing HD are extremely varied. Common scenarios are noted in the table. Two unusual responses happened in individuals being tested to reduce anxiety. One patient with an active somatization process decompensated when learning that the test was negative and HD could not account for symptoms. Another patient returned to work able to concentrate for the first time in several years despite the knowledge of a positive result; however, the patient's non-HD mother became quite depressed.

More than 50% of the candidates decline testing when behavioral outcomes or compromises in confidentiality are discussed. One patient was thought to be planning suicide after demanding examinations too quickly to allow assessments and case review, then using a lawyer to obtain release of information by

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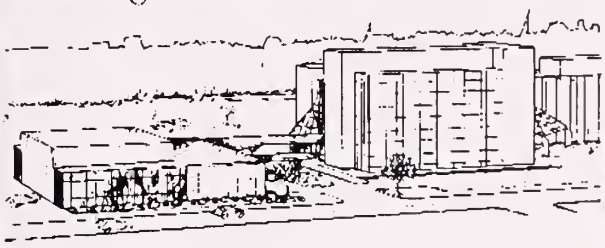

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phone before the planned disclosure. Since the results were negative, the suicidal act was not necessary.

In many cases the most compelling personal reason to seek presymptomatic testing is not apparent to the patient at the time of the initial inquiry. One of the primary roles of counseling and team evaluation is to help uncover motivations for testing which will have behavioral effects after disclosure.

Although patients are not refused testing, advice to delay testing is made when the patient is having mood or adjustment problems or is anticipating divorce. The former should not seek behavioral treatment until ready. The latter should anticipate a positive result being a threat to a settlement rather than an opportunity to remove a possible stigma by hoping for a negative result.

Discussion

It is clear from our experience that individuals at risk for HD are not only seeking a test result but a major change in their perspective on life, their sense of worth, and their ability to cope with the future. The emotional aspects accompanying linkage analysis may be unique in intensity because of the requirement to obtain tissue samples from affected relatives. We have recently begun direct genetic testing using the polymerase chain reaction to quantify the abnormally high CAG nucleotide codon repeats characteristic of the DNA in HD.

In line with other genetic testing groups we are using the same multidisciplinary team approach to ensure an effective outcome for the patient. Although indeterminate results are less likely with the large number of genetic probes available for linkage analysis, one case of indeterminance was resolved with a direct test showing inheritance. The patient is now in counseling to assist adjustment to this undesirable resolution to the ambivalence. The direct DNA test can also be indeterminate if there is only a borderline elevation in the number of CAG repeats. One additional benefit of the direct test is the resolution of atypical movement disorders especially when there is no family history or if there are early ambivalent signs in at-risk individuals with a well documented family history.

With the many new genetic tests becoming commercially available and the popular demand to know genetic risk growing in the community, we must view our patient care responsibility to include an informed counseling commitment. Well-trained practitioners and counselors may be suited to the task, but consultation with medical geneticists can be used to clarify complicated genetic mechanisms and counseling requirements.

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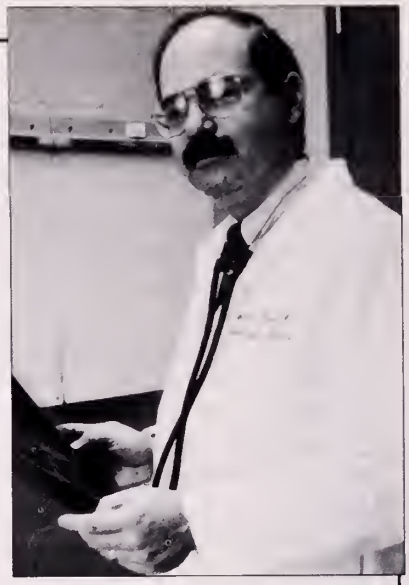

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Outcomes of resuscitative efforts at Wild Rose Hospital

Dan H. Fifield, MD, Wild Rose

A review of resuscitative outcomes in a small, rural hospital was performed for the purpose of comparing results with previous studies from other institutions. Chart reviews and staff interviews were conducted for the data base. In the period July 1991 through July 1993, 11 patients had cardiac or respiratory arrests: 100% regained a perfusing rhythm, with 37% surviving to discharge. These results exceeded reperfusion and survival rates in previously published studies and may form the basis of future research. *Wis Med J.1994;93(2):55-57.*

THE INITIATION OF cardiopulmonary resuscitation on a widespread basis began after Knickerbocker and Kouwenhoven published results of their efforts in 1960.[1] The success of resuscitative efforts has since been examined during the intervening three decades, and recently the value of these interventions has been questioned with regard to short- and long-term outcomes.

A variety of authors from diverse settings have reported their findings. These range from Medford[2] relating the results in a community hospital in West Virginia in 1966 to Bedell's[3] prospective study at Harvard in 1983 and Von Gunten's[4] review of resuscitative outcomes in 1991 (Table 1). The majority of these studies were conducted prior to the initiation of standards that have been applied during the past 10 years; most notably advanced cardiac life support (ACLS) protocols and, possibly more relevant, the emphasis on advance directives as a screening mechanism which eliminated many of those with numerous, chronic or terminal conditions from truly futile resuscitative efforts.

Von Gunten's review of numerous studies relating to resuscitation outcomes showed 62% of the patients died initially, 25% died prior to discharge, and 13% survived to discharge. When data were further restricted to resuscitation efforts performed on a general medical floor, the results were even more dismal, with only 4% of the patients surviv-

Table 1.—Outcome of CPR in hospitalized patients.

Study	Number of patients	Mean age, if given (years)	Died initially (%)	Died before discharge (%)	Survived to discharge (%)
Bedell, et al.	294	70	56	30	14
Gulati, et al.	52	76	73	10	17
Hershey and Fisher	88		44	41	15
Peatfield, et al.	1,063		67	24	9
Messert and Quaglieri	183	65	74	12	14
Lemire and Johnson	1,204	60	81†	†	19
Castagna, et al.	137	69	65	25	10
Hollingsworth	368	54	75	16	9
Johnson, et al.	552		68	17	15
DeBard	1,073	60	43	33	24
George, et al.	140		45	31	24
Taffet, et al.	77	77	69	31	0
Taffet, et al.	322	59	57	36	7
Murphy, et al.	503		78	18	4
Weighted average			62	25	13

*The patient populations include intensive care unit, coronary care unit and emergency department patients, as well as those on the general ward or in other areas of the hospital.
† In this study, patients who died initially were not distinguished from those who died before discharge. These data are excluded from the weighted average calculation.

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ing to discharge. Peterson's[5] review of medical intensive care patients yielded similar results, with 11% surviving to discharge. Similar results are currently being obtained by M. Thel at the Duke University Medical Center (personal communication, July 1993).

With the exception of Medford's study, 17 years ago, little has been done to quantify outcomes of resuscitative efforts in small community hospitals, and lacking clear data for anticipating outcomes of interventions, we felt it necessary to evaluate our performance for comparison to broader surveys as they develop.

Method

A retrospective study was performed at Wild Rose Community Memorial Hospital, a 29-bed acute care facility in a rural area of Wisconsin. Thirteen resuscitation efforts were examined, which constituted all in-house codes called from July 1991 through July 1993.

Three of the codes were called on one patient during two separate hospitalizations. Otherwise, all resuscitation efforts involved individual patients and occurred either in the hospital or on hospital grounds.

Codes are defined as loss of spontaneous respirations, perfusing heart rhythm, or unmeasurably low blood pressure. Staff interviews and chart reviews were conducted for our data base.

Results

A reperfusing rhythm was obtained in all patients resuscitated. Seven (64%) died prior to discharge, in a time ranging from 2 days to 2 months. Four patients (36%) survived to discharge and, as of this writing, two are currently alive.

Of those surviving to discharge, co-morbidity ranged from none to an undiagnosed gastrointestinal malignancy; age alone did not appear to be a factor (Table 2).

All but one patient who survived initial resuscitation efforts were transferred to tertiary care centers. Two of these patients then returned to Wild Rose where, as specified by their advance directives, one was successfully resuscitated twice, and the other allowed to expire without further intervention.

Discussion

Comparison of data would indicate favorable outcomes when compared to previous studies. Bias is certainly introduced in the motivation for this retrospective, in that the initial observation that "a lot of people seem to survive their codes here," is what prompted this investigation.

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Eleven patients and 13 events do not constitute a sufficient statistical base to work with in regard to factors influencing outcomes. What can be stated is that the small size of our facility precludes the possibility of an unwitnessed arrest. All of our events were witnessed, and resuscitation started in less than a minute, usually with all equipment and personnel in place.

The small size of the hospital also refers to the limited number of nurses and physicians on staff. This allows the hospital to mandate that all nurses and physicians are trained in ACLS and continue to exhibit proficiency in resuscitative skills. There is no need to rely on a "code team" and, therefore, no delay between the initiation of CPR and the subsequent use of ACLS protocols.

Resuscitative methods and outcomes will continue to be followed at our institution and comparisons made with other hospitals in an effort to identify developing trends.

Table 2.—Resuscitation outcomes.

Patient	Age	Symptoms/ Diagnosis	Location	Code type	Outcome
No. 1	77	Chest pain	Emer.Room	Cardiac	++
No. 2	83	Abd.pain	Emer.Room	Cardiac	++
No. 3	87	Dyspnea on exer	Floor	Resp	+++
No. 4	87	Dyspnea on exer	Floor	Resp	+++
No. 5	87	Dyspnea on exer	Floor	Resp	+++
No. 6	41	Chest pain	Emer Room	Cardiac VtachVfib	+++
No. 7	58	Dyspnea	Emer Room	Resp	+
No. 8	67	Abd/chest pain	Floor	Asystole/ V fib	+++
No. 9	61	Syncope	Emer Room	V fib	++
No. 10	67	EMD/hemor shock	Emer Room	EMD	+
No. 11	74	Syncope	OP Dept	Asystole	+++
No. 12	86	Dyspnea/CP	Emer Room	Tachy/ hypoten	++
No. 13	74	Syncope	Emer Room	Asystole	++

\+ Perfusing rhythm
++ Survived > 24°
+++ Survived to discharge
Patient No. 3, 4, 5 is same patient

Dr Fifield is with the Wild Rose Clinic in Wild Rose. Reprint requests to: Dan H. Fifield, MD, Wild Rose Clinic, Ltd., PO Box 314, Wild Rose, WI 54984. Copyright 1994 by the State Medical Society of Wisconsin.

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LEEP: Early experience with a new approach to cervical lesions

Jerome H. Gundersen, MD, and Sheila Nichols, La Crosse

The loop electrosurgical excision procedure (LEEP) is a new diagnostic and therapeutic approach for the management of cervical lesions found during the evaluation of abnormal findings from Papanicolaou smears. The procedure may be an alternative to laser therapy, cold knife conization, cryotherapy or hot cautery. The first 235 consecutive LEEPs performed at the Gundersen Clinic were reviewed 6 months after the last procedure was done. Twelve of 187 patients with follow up Papanicolaou smears and clinic visits had persistent disease. Nine of 187 patients had a repeat LEEP. LEEP was found to be a highly effective means for diagnosis and treatment as 98% of the patients were free of evidence of recurrent cervical lesions 6 months after the initial LEEP. *Wis Med J.1994;93(2): 58-62.*

SINCE THE INTRODUCTION of the Papanicolaou smear in the United States in 1943, the number of deaths from cancer of the cervix has decreased by 70%. The recent introduction of the Bethesda system (TBS) of reporting Papanicolaou smear results has resulted in an unexpectedly large number of patients needing evaluation or treatment.

Treatment for pre-invasive lesions of the cervix has undergone significant changes. The initial treatment for carcinoma in situ often included a hysterectomy with node dissection. There are many treatment options for pre-invasive lesions of the cervix. These options include: cold knife conization, cryosurgery, laser therapy, hysterectomy, and the recently introduced loop electrosurgical excisional procedure (LEEP).

TBS reporting of Papanicolaou smear results has created new terminology that is gaining acceptance in the United States. Atypical squamous cells of undetermined significance, low-grade squamous intra-epithelial lesions, and high-grade squamous intra-epithelial lesions are terms used to replace the class system and cervical intra-epithelial lesion designation of the past (Table 1).

Cartier advocated the uses of small loop for investigating and treating cervical lesions since 1984.[1] Prediville, et al, reported on loop biopsy results in 1986[2] and the large loop for therapy in 1989.[3] Large series have been reported in the European literature. With one, by Bigigg,

Table 1.--Reporting squamous cell cytologic diagnoses.

Bethesda system	Classic system		Modified Papanicolaou system
Benign within normal limits	Normal		I
Infection (organisim should be specified)	Inflammatory atypia (organism)		II
Reactive and reparative changes			
Atypical squamous cell abnormalities			
Atypical squamous cells of undetermined significance	Squamous atypia of uncertain significance		IIR
	HPV atypia		IIR
Low-grade squamous intraepithelial lesion	Mild dysplasia	CIN 1	III
High-grade squamous intraepethelia lesion	Moderate dysplasia	CIN 2	III
	Severe dysplasia	CIN 3	III
	Carcinoma in situ	CIN 3	IV
Squamous cell carcinoma	Squamous cell carcinoma		V

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reporting good results in 1,000 patients treated at the initial visit to evaluate an atypical Papanicolaou smear result.[4] All reports confirm the high cure rate, ease of performance, low side effects and low cost of the LEEP. There are not yet large enough series to show the long-term effect on pregnancies, but several small series have reported no increased complication noted during pregnancy following loop electrosurgical excision.[5]

The use of the colposcopically guided LEEP to diagnose and treat atypical Papanicolaou smear results in our first 235 patients is reviewed in this paper. We feel this procedure may allow for modification of current management regimens of atypical Papanicolaou smear results and colposcopically identified cervical lesions.

Table 2.--LEEP data and diagnoses.

LEEP data on 235 patients		
Pre LEEP cervigram	203 pts	86%
Pre LEEP biopsy (185 pts)	198 (185 pts)	84%
Post LEEP Pap smears (> 6 mos)	192 pts	81%
Post Leep Pap smears > ASCUS	27 pts	11%
LEEP diagnoses on 239 patients		
Negative	21 pts	9%
LGSIL	85 pts	35%
HGSIL	130 pts	54%
Micro-invasive	2 pts	< 1%
Inadequate	1 pt	< 1%

ASCUS = atypical squamous cells of undetermined significance
LGSIL = low-grade squamous intra-epithelial lesions
HGSIL = high-grade squamous intra-epithelial lesions

Table 3.--Correlation of findings from pre-LEEP biopsy specimens and LEEP specimens.

		pre-LEEP biopsy									
		NEGATIVE		HPV-CIN I		CIN-II		CIN-III		TOTAL	
LEEP	NEGATIVE	0		9	13%	1	2%	0		10	5%
	HPV-CIN I	8	100%	45	63%	13	25%	12	23%	78	42%
	CIN-II	0		12	17%	28	53%	9	17%	49	26%
	CIN-III	0		5	7%	11	21%	31	58%	47	25%
	MICROINV	0		0		0		1	2 %	1	<1%
	TOTAL	8	4 %	71	38 %	53	29%	53	29 %	185	

Methods

Equipment for performing LEEP in a gynecologic office treatment room was available at Gundersen Clinic starting Aug 21, 1991. From Aug 21, 1991, to June 1, 1992, 235 patients underwent a LEEP (Table 2). Eight of these were done with the patient under general anesthesia at La Crosse Lutheran Hospital, usually in the same-day surgery unit. The patients were evaluated for this procedure by the gynecologic colposcopists of the division of colposcopy and cervical pathology at the Gundersen Clinic.

There are about 25,000 Papanicolaou smear specimens processed per year at the Gundersen Clinic with 1,300-1,400 colposcopies done. The abnormal Papanicolaou smear results consist of approximately 3.5% atypical cells of undetermined significance, 1.5% low-grade squamous intra-epithelial lesion, and 0.5% high-grade squamous intra-epithelial lesion. Therefore, the pathological findings of approximately 5% of the Papanicolaou smear specimens result in referral of the patient for colposcopy as recommended by the division of colposcopy and cervical pathology. Additional patients may be referred by local physicians and family planning clinics and other educational institutional health centers where Papanicolaou smears are done.

The patients had follow-up Papanicolaou smears at 6 months after the LEEP. Fifty percent had a cervigram, a colposcopy, or both 6 months after the LEEP. (Cervigrams are photographic cervical slides made using the cervicography system developed by Dr Adolf Stafl of the Medical College of Wisconsin and currently processed by National Testing Laboratories, Inc., of Fenton, MO.) All patients were reevaluated if the post-LEEP Papanicolaou smear specimen had a reading of atypical cells of undetermined significance, low-grade squamous intra-epithelial lesion or high-grade squamous intra-epithelial lesion. The follow-up of these patients was facilitated by using a computerized registry of abnormal Papanicolaou smear results as previously described in the *Gundersen Medical Journal* 1991;1(Dec):1.

The LEEP was done by standard techniques described by several authors using colposcopic guidance with a Valley Lab Cautery Force II Electrocautery Unit.[4-6] Patients were advised to have an evaluation by the colposcopist 6 months after the LEEP. The cervigram was frequently used to document both before elec-

trosurgical excision procedure and after electrosurgical excision procedure findings. Patients with post-operative abnormalities of the Papanicolaou smear specimen were evaluated and follow up procedures were performed as decided by the individual colposcopist. Particular attention was given to the pathologic interpretation of the ectocervical and endocervical borders of the lesion. Cases in need of further diagnosis or therapy were managed by standard practices now being used for abnormal Papanicolaou smear results.

All charts were reviewed to evaluate the pre-LEEP Papanicolaou smear results, biopsy specimens, cervigrams, treatments, post-LEEP examinations, complications, the pathologic diagnosis, post-LEEP Papanicolaou smear results, and the need for further treatment.

Results

Eighty-four percent of the patients had a cervical biopsy prior to the LEEP. The biopsy findings and the LEEP findings showed a good correlation. This correlation was best if the biopsy results showed cervical intra-epithelial neoplasm II or cervical intra-epithelial neoplasm III. Only one patient with a cervical intra-epithelial neoplasm II or cervical intra-epithelial neoplasm III finding from the biopsy had no pathologic diagnosis at time of the LEEP. Twenty-four percent of the cervical biopsies diagnosed as cervical intra-epithelial neoplasm I later demonstrated cervical intra-epithelial neoplasm II or cervical intra-epithelial neoplasm III on histologic diagnosis of the operative specimen (Table 3).

The comparison of the Papanicolaou smear and LEEP pathologic diagnoses showed a poor correlation: 28% of patients with negative results from Papanicolaou smears and 41% of patients with atypical cells of undetermined significance in the Papanicolaou smear specimen had cervical intra-epithelial neoplasm II or cervical intra-epithelial neoplasm III in the LEEP. With all abnormal Papanicolaou smear readings there were significant numbers of high-grade squamous intra-epithelial lesions detected after LEEP histologic diagnosis. Papanicolaou smear specimens with atypical cells of undetermined significance yielded 41% high-grade squamous intra-epithelial lesions; Papanicolaou smear specimens with low-grade squamous intra-epithelial lesions yielded 52% high-grade squamous intra-epithelial lesions; and Papanicolaou smear specimens with high-grade squamous intra-epithelial lesions yielded 77% cervical intra-epithelial neoplasm II or cervical intra-epithelial neoplasm III (Table 4).

On evaluation of LEEP specimens, 62 of 235 patients had margins of the specimen that contained cervical intra-epithelial neoplasm or possible cervical intra-epithelial neoplasm. In the group with margins involved or possibly involved with cervical intra-epithelial neoplasm, 88% had negative Papanicolaou smear results at 6 months; whereas, 82% of the patients with clear pathological margins had negative Papanicolaou smear results at 6 months. The finding of clear endocervical and or ectocervical margins compared to possibly or definitely involved margins had equivalent numbers of abnormal Papanicolaou smear results at 6-month follow-up.

This is not the findings of Shafi, et al.[7] Their report indicated that large size of the lesion and involvement of the margins were accompanied by increased abnormal post-LEEP Papanicolaou smear results. The extent of each lesion was not evaluated in this review.

Patients with post-LEEP atypical cells of undetermined significance in the Papanicolaou smear specimens may have a repeat Papanicolaou smear in 6 months without needing colposcopic evaluation. High-grade and low-grade lesions probably should have follow up colposcopic evaluation to rule out recurrent or residual cervical intra-epithelial neoplasm lesions. Twenty seven of the 187 patients seen in follow up had abnormal Papanicolaou smear results 6 months after the LEEP (Table 1).

Evaluation of atypical cells of undetermined significance or more severe abnormalities of the Papanicolaou smear specimens led to nine repeat LEEPs and three biopsies revealing cervical intra-epithelial neoplasm I in seven patients and cervical intra-epithelial neoplasm III in five. The margins of the first LEEP were clear in all of the five patients

Table 4.--Comparison of pre-LEEP Papanicolaou smear findings and LEEP findings.

		pre-LEEP Papanicolaou smear results									
		NEGATIVE		ASCUS		LGSIL		HGSIL		TOTAL	
	NEGATIVE	4	19%	8	11%	6	7%	5	6%	23	8%
	HPV-CIN I	11	52%	33	47%	35	41 %	13	16%	91	39%
L	CINII	3	14%	9	13%	25	29%	20	25%	57	24%
E											
E	CINIII	3	14%	19	27%	20	23%	40	51%	82	35%
P	MICROINV	0		1	1%	0		1	1%	2	< 1%
	TOTAL	21	9 %	70	30 %	86	36 %	79	33 %	236	

with cervical intra-epithelial neoplasm III diagnosed after a second LEEP. At the time of the second LEEP, the margins were free in all of the repeat LEEPs done on patients with recurrent cervical intra-epithelial neoplasm III.

In total, 94% of the patients followed from initial treatment were free of disease in 6 months, as indicated by finds from Papanicolaou smears and cervigrams. Four percent (9) of the patients received a second LEEP, leaving 98% of patients free of any evidence of cervical intra-epithelial neoplasm at the time of this review. Two patients have low-grade squamous intra-epithelial lesions that are being followed, and one has a high-grade squamous intra-epithelial lesion and is pregnant and will be evaluated post partum.

Complications were rare, and no patient required late treatment for complications of the LEEP. Vaginal bleeding at the time of the LEEP required suturing or extensive cautery three times. No reported post-operative febrile illnesses were seen. One patient was readmitted to the hospital for uterine bleeding related to a dilation and curettage that was done at the time of the LEEP.

Of the patients with cervical intra-epithelial neoplasm II or cervical intra-epithelial neoplasm III found by colposcopically directed biopsies, 78% (80/103) had high-grade squamous intra-epithelial lesion or microinvasion in the LEEP specimen (Table 3). Of the patients with pre-LEEP Papanicolaou smear findings of low-grade squamous intra-epithelial lesion or high-grade squamous intra-epithelial lesion, 64% (105/165) had high-grade squamous intra-epithelial lesion detected by LEEP (Table 4). If the cervigram result was atypical or positive, 61% (99/162) had a high-grade squamous intra-epithelial lesion and 33% (54/162) had low-grade squamous intra-epithelial. In total, 94% of the patients with atypical or positive cervigram findings had cervical intra-epithelial neoplasm on pathologic examination of the LEEP specimen (Table 5).

Discussion

After proper evaluation by various combinations of colposcopy, Papanicolaou smear, cervigram, and cervical biopsy, LEEP has proven to be a highly safe, acceptable, and effective method of diagnosis and treatment of cervical intra-epithelial neoplasm. The number of patients having a LEEP represent a small percentage of the patients in each Papanicolaou smear category.

The number of pre-LEEP false negative Papanicolaou smear results (9%) and false negative cervigram findings (17%) lend credibility to the importance of careful follow-up and evaluation of any patient with a history of an abnormal Papanicolaou smear results. Fully 10% of patients evaluated with an atypical cells of undetermined significance in the Papanicolaou smear specimen at the Gundersen Clinic have cervical intra-epithelial neoplasm II or cervical intra-epithelial neoplasm III on biopsy (unpublished date from Gundersen Clinic, Ltd).

The ability to resolve the significance of an abnormal Papanicolaou smear results by an office evaluation using the LEEP still leaves many management problems to be resolved. Should all patients with a minor lesion have a LEEP or just be carefully followed? Should LEEP replace office biopsy? Who should be doing a LEEP? What is the role of human papilloma virus testing and typing? What is the appropriate evaluation of patients with Papanicolaou smear specimens showing atypical cells of undetermined significance and low-grade squamous intra-epithelial lesions?

Prospective studies are needed to answer the questions apparent in the current approach to atypical Papanicolaou smear results and proven low-grade squamous intra-epithelial cervical lesions.

High cure rates of 85% to 95% are reported with all modalities of treatment.[9-11] The ablative techniques potentially conceal more significant lesions as demonstrated by the unsuspected presence of two micro-invasive carcinomas (Table 2).

If patients having biopsy specimens with minor-grade lesions or Papanicolaou smear specimens with atypical cells of undetermined significance or low-grade squamous intra-epithelial lesions were observed over time without intervention, a large number of these LEEPs may not have been required. It is estimated that only 20% of low-grade squamous intra-epithelial lesions progress to higher grade lesions.[8] If patients with atypical cells of undetermined significance in their Papanicolaou smear specimens and low-grade squamous intra-epithelial lesions in their biopsy specimens were carefully followed, there would have been a significant number of

Table 5.--Comparison of pre-LEEP cervigram results and LEEP findings.

		pre-LEEP cervigram results				
		NEGATIVE	ATYP	POS P1,P2	TD	TOTAL
LEEP	NEGATIVE	5 15%	2 8%	7 5%	0	14 7%
	HPV-CIN I	18 53%	10 40%	44 32%	3 43%	75 37%
	CINII	6 18%	2 8%	32 23%	2 29%	42 21%
	CINIII	5 15%	11 44%	52 38%	2 29%	70 34%
	MICROINV	0	0	2 1 %	0	2 <1 %
	TOTALL	34 17%	25 12%	137 67%	7 3%	203

undiagnosed high-grade squamous intra-epithelial lesions. It is probable many of these undiagnosed high-grade squamous intra-epithelial lesions would eventually need treatment, although they would most likely become clinically apparent with appropriate follow-up. Rapid progression to invasive cancers is very rare making immediate treatment of low-grade squamous intra-epithelial lesions probably less critical if appropriate evaluation and follow-up occurs.

It is currently recommended by the Gundersen Clinic's division of colposcopy and cervical pathology that all patients with atypical Papanicolaou smear results receive colposcopy by a trained colposcopist. It is also recommended that the LEEP be done by an experienced colposcopist with gynecological surgical experience. The uncertainties in the area of atypical Papanicolaou smear results, including the choice of treatment versus careful follow-up of biopsy-proven low-grade squamous intra-epithelial lesion cervical lesions, and the confusion over the significance of the presence of human papilloma virus, resulted in individualization of care within our institution.

Even given these uncertainties, after careful evaluation and under colposcopic visualization, LEEP is a highly safe and effective way to manage and further diagnose cervical lesions.

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Public health

Asthma hospitalizations in Wisconsin: public health implications

Jay Goldring, PhD; Lawrence Hanrahan, PhD, MS; and Henry Anderson, MD; Madison

Analysis of national asthma statistics has identified a number of disturbing trends.[1] Between 1979 and 1988, self-reported asthma prevalence has increased by approximately 40%. During the same period, the age-adjusted death rate for asthma as the underlying cause of death increased 46% from 1.3 per 100,000 population to 1.9 per 100,000.

Asthma prevalence among black Americans is approximately 50% greater than that among white Americans. The reasons for this rate disparity are complex and multifactorial. In previous studies, asthma prevalence has been correlated with poverty, maternal smoking, low birth weight, living in a small space and nutritional status. These risk factors are more prevalent among blacks.[2]

The occurrence of asthmatic episodes has been associated with exposure to aeroallergens such as animal dander, molds, dust mites[3] or air pollutants such as cigarette smoke,[4,5] particulates,[6] sulfur dioxide,[7] or acidic aerosols.[8] Black Americans may be differentially exposed to these agents.[9] Genetic differences in lung function and volume, perhaps leading to differential susceptibility to the effects of air pollutants, may also play a role in the observed racial rate difference.[10]

In the United States, approximately 190 individuals per 100,000 population are admitted to the hospital with a first-listed discharge diagnosis of asthma.[11]

Nationally, the asthma hospital discharge rate for blacks is twice that for whites. Trends in asthma-related hospitalization, in addition to asthma prevalence, may reflect socioeconomic factors such as access to health care. This statistic, however, has been widely used as a measure of asthma morbidity. The US Public Health Service has stated the following goals in "Healthy People 2000: National Health Promotion and Disease Prevention Objectives"[12]:

11.1. Reduce asthma morbidity, as measured by a reduction in asthma hospitalizations to no more than 160 per 100,000 people.
- 11.1a. Reduce asthma morbidity among blacks and other nonwhites, as measured by a reduction in asthma hospitalizations to no more than 265 per 100,000 people.
- 11.1b: Reduce asthma morbidity among children, as measured by a reduction in asthma hospitalizations to no more than 225 per 100,000 people.

To monitor Wisconsin's progress toward this objective, Wisconsin hospital discharges with asthma as the first-listed diagnosis were examined and appropriate public health responses to these trends are discussed.

Continued on next page

The public health column is not reviewed by the *WMJ* editorial board. Dr Goldring is a toxicologist and Dr Hanrahan is an epidemiologist in the Section of Environmental Epidemiology and Prevention, Bureau of Public Health. Dr Anderson is chief medical officer for Occupational and Environmental Health in the Bureau of Public Health. Requests for reprints to: Jay Goldring, PhD, Wisconsin Division of Health, 1414 E Washington Ave, Room 96, Madison, WI 53703-3044. Copyright 1994 by the State Medical Society of Wisconsin.

Continued from preceding page

Methods

Since 1989, Wisconsin has required hospitals to report all discharges to the Office of Health Care Information. Race has been an included data element since July 1, 1990. This study examined all discharges occurring between July 1, 1990, and June 30, 1992, which listed asthma (ICD 493) as the principal discharge diagnosis. For comparison purposes, discharges listing pneumonia and influenza (ICD 460 to 466) and acute respiratory infections (ICD 480 to 487) as the principal discharge diagnosis were also examined.

Age-, sex-, and race-specific discharge rates were calculated and summary age adjusted rates were constructed for each condition using Wisconsin 1990 census statistics. Discharge rates by payment source were calculated using statistics from the Wisconsin Bureau of Health Care Financing. Geographic rate analysis was performed using ZIP code of residence, and repeat admissions for the same individual were determined by matching ZIP code of residence and birth date.

Average yearly hospital charges and length of stay were calculated for each group. Only one discharge per person was used for the rate analysis, but all discharges, including repeats, were used for average charge and length of stay calculations. "Excess" annual asthma-related hospital charges for high risk groups, defined as the difference between the charges for the specific group and the expected charges derived from a random sample of a similar age composition, were calculated using the following formula: Excess charges = (observed number of discharges - expected number of discharges) x average charge of a hospital stay for that group. The expected number of discharges was calculated using the statewide age-, sex-, and race-specific rates. Charges do not include physician fees.

Results

Between July 1, 1990, and June 30, 1992, 9,852 Wisconsin residents were discharged from Wisconsin hospitals with a diagnosis of asthma an average of 1.3 times for a total of 13,161 hospitalizations. When repeat discharges were eliminated, the statewide yearly rate of asthma-related hospital discharges for all ages was 100 per 100,000.

Area-specific rates ranged from 2.6 per 100,000 along Wisconsin's western border (probably artificially low due to unidentified hospitalizations in Iowa and Minnesota) to 390 per 100,000 in western Milwaukee city.

Among children under 15, the

Continued on page 66

Table 1.-- Age-adjusted yearly Wisconsin hospital admission rates per 100,000 population for asthma, pneumonia and influenza, and acute respiratory infections: July 1990 through June 1992.

Group	Asthma	Pneumonia influenza	Acute resp infection
		All ages	
Wisconsin	100 (n=9,860)	311 (n=30,676)	125 (n=12,277)
Males	93 (n=4,507)	391 (n=17,081)+	136 (n=6,413)
Females	107 (n=5,353)	295 (n=15,758)	115 (n=5,864)
Blacks	366 (n=1,947)++	496 (n=1,824)++	225 (n=1,168)++
Whites	74 (n=6,631)	265 (n=24,477)	105 (n=9,317)
American Indians	69 (n=62)	347 (n=220)	102 (n=87)
Medicaid recipients*	181@(n=2,187)	472@(n=3,259)	151 (n=5,998)
Non-Medicaid recipients*	78 (n=5,565)	363 (n=10,385)	90 (n=2,394)
		Age <15	
Wisconsin	180 (n=4,036)	263 (n=5,764)	104 (n=5,794)
Males	233 (n=2,608)+	184 (n=3,527)	112 (n=3,569)
Females	138 (n=1,454)	168 (n=2,267)	96 (n=2,225)
Blacks	661 (n=1,103)++	318 (n=50)++	214 (n=661)++
Whites	124 (n=2,373)	134 (n=3,362)	86 (n=4,208)
American Indians	140 (n=36)	181 (n=34)	83 (n=60)
Medicaid recipients*	245 (n=1,646)	237 (n=2,336)	250 (n=2,031)
Non-Medicaid recipients*	128 (n=3,008)	67 (n=4,331)	187 (n=4,163)

* Calculations based upon Medicaid status are for individuals under 65. "Non-Medicaid recipients" includes those on other forms of governmental assistance, private insurance, self-pay and unknown payer status.

\+ Significantly different from the corresponding female rate ($p<0.001$).

++ Significantly different from the corresponding white rate ($p<0.001$).

@ Significantly different from non-Medicaid recipients ($p<0.001$)

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Continued from page 64
statewide rate was 180 per 100,000 and ranged from 26 per 100,000 along the western border to 702 per 100,000 in western Milwaukee.

The highest asthma-related hospital discharge rates were in central, northern and western areas of the City of Milwaukee. Other places significantly higher than the state rate were areas in Racine, Kenosha and Beloit ($p < 0.001$) and areas in Madison, Waukesha and Green Bay ($p < 0.05$). All other areas of the state, including the urban areas of La Crosse, Eau Claire, and Wausau, were either below or not significantly different from the overall state rate.

During the study period, asthma-related hospital discharge rates for blacks were more than five times as high as those for whites for all ages, while asthma discharge rates for American Indians were not significantly different from those for whites (Table 1).

Pneumonia and influenza rates and acute respiratory infection discharge rates had similar patterns to those for asthma (Table 1). For both conditions, discharge rates for blacks were approximately twice those for whites. Higher discharge rates for these conditions were also noted for Medicaid recipients than for the entire state.

The average length of stay for an asthma hospital admission was 3.68 days and did not significantly differ between groups. Significantly more blacks (25%) than whites (18%) or American Indians (22%) had multiple hospital admissions with a discharge diagnosis of asthma during the study period ($p<0.001$). Among Medicaid recipients, the percentage of blacks admitted to the hospital for asthma more than once over the study period significantly excceded that for whites (29.0% v 23.3%, respectively, $p<0.001$). Similar results were found among private insurance recipients (21.4% v 16.4%; $p<0.001$).

Calculated excess charges of asthma admissions among blacks, Medicaid recipients and central Milwaukee residents are shown in Table 2. Excess direct charge estimates per year ($3 million, $1.8 million, $2.4 million) for each group, not including physician fees, are significant.

Discussion

Wisconsin's asthma hospital admissions rate is slightly more than half of the national rate (100 v 190 per 100,000; Table 1), already achieving the year 2000 goals set by the US Public Health Service for both adults and children. The rate for blacks, however, is more than five times that for whites, and is significantly above the year 2000 objectives (366 v 265 per 100,000).

The factors contributing to the racial rate difference in asthma hospitalizations are complex. In a previous study, the threefold difference found between asthma-related hospital admission rates for black and white children under the age of 15 was attributed exclusively to differences in socioeconomic status.[13] In this study, the asthma-related admissions rate for Medicaid recipients (used as an indicator of socioeconomic status) was only twice that of non-Medicaid recipients, suggesting that socioeconomic status was likely a major contributing factor but not fully explaining the rate difference among races.

A number of other factors may contribute to the high rate of asthma-related hospitalizations among Wisconsin blacks. In Wisconsin this group has a higher likelihood of being under-insured or uninsured.[14] Illnesses in uninsured individuals without primary care are generally felt to be more severe by the time a physician visit occurs and thus more likely to require hospitalization than in insured individuals.[15]

In this study, the rate differences among races were also seen for the other conditions evaluated (pneumonia and influenza and acute respiratory infection--Table 1), but the difference in asthma hospitalization rates was much more pronounced than that for these other conditions. Multiple factors must be operable because the rate difference among races observed is present regardless of payer status (Table 1).

Wisconsin professional and community efforts to reduce asthma morbidity among black Americans can focus immediately on two specific objectives: preventing the circumstances that may cause the condition to develop in the black population, and identifying individuals at high risk for asthma-related emergency room visits or hospital admissions.

Table 2.--Calculated yearly excess charges of asthma hospital admissions (excluding physician fees) among blacks, Medicaid recipients and central Milwaukee residents: July 1990 through June 1992.

Group	Observed admissions	Expected admissions	Average charge	Yearly excess charge
Blacks	1,947	241	$3590.98	$3,009,073
Medicaid recipients	2,187	1,063	$3255.12	$1,829,377
Milwaukee residents	2,115	1,310	$3695.84	$2,420,775

The first objective can be approached through: community asthma awareness and understanding education; anti-smoking and clean indoor air regulations; and implementation of outdoor air pollution legislation, such as the Clean Air Act Amendments of 1990. School-based asthma education programs such as the American Lung Association's "Open Airways" can help prevent hospitalizations[16] but their long-term efficacy has not been completely evaluated.

The second objective will be addressed initially in Milwaukee through a pilot asthma surveillance project sponsored by The Council of State and Territorial Epidemiologists. The Wisconsin Division of Health and Medical College of Wisconsin are responsible for implementation. The goal of this project is to better understand risk factors leading to asthma morbidity through identification of high-risk individuals. This goal will be achieved by facilitating better communication and response coordination between community groups, medical care providers, and state, county and city public health programs.

Initial efforts in this project will focus on describing the characteristics of children and young adults at high risk of asthma-related emergency room visits or hospitalizations. This information should result in better targeting of education related to asthma control and prevention and provide a mechanism to evaluate subsequent intervention programs.

Conclusion

Wisconsin has already achieved the overall National Public Health Service year 2000 goal for asthma hospitalizations. Wisconsin rates for hospitalizations of black patients, however, are significantly above the goal for that sub-population. Achieving the black asthma-related hospital admissions goal will require increased provider and public awareness of the seriousness of asthma.

This must be followed by cooperation among health care providers, public health agencies, educators, and community activists to renew prevention efforts. Each must assist in identifying and overcoming barriers to preventing avoidable asthma-related hospitalizations. By providing support and education to high-risk individuals, avoidable asthma-related hospitalizations can be reduced and asthma fatalities may be prevented.

Acknowledgements

The authors appreciate the assistance of Patrick Remington, MD, in reviewing drafts of this manuscript. Also, the Wisconsin Office of Health Care Information provided data for this analysis and reviewed the analysis and its assistance is appreciated.

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AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

Correction: William Schlenker, MD, (l) was misidentified in this photo, appearing in the January WMJ, *as William Bartlett, MD. Dr Schlenker was part of the signing ceremony with Gov Thompson (r) for the Public Health Statute Revisions bill.*

December 1993

* Ahmad, Muhammad Yusof
* Basu, Sailendra Nath
Beltran, Luciano Rosario
* Berg, Eric Roy
* Bhore, Jay Narayan
* Bice, James Bradley
* Bock, Harvey Michael
Caffrey, James F.
* Christensen, Dennis Dean
* Fejer, Szabolcs I.
* Finch, David Richard
* Fleming, Paul Michael
* Grieshaber, Gordon James
* Hyndiuk, Robert Anthony
* Jacobi, Michael Anton
* Karen, Robert
* Kelley, William Bernard
* Knuth, Ronald Chas.
* Kochar, Mahenor Singh
* Korkos, George James
* Leehey, Paul Jos.
* Lichty, James Edward
* Magnin, George Ernest
Maski, Ravikant
* Miller, Thomas Orlin
* Noble, John Henry
* Olson, Reid Martin
* Peterson, Stanley Eugene
* Potek, Arnold S.
* Saarinen, David Michael
Sennett, Louis W.
Shim, Jae Yong
* Sipes, Don Ralph
* Smith, Franklin Adams
* Teplin, Ervin
* Wolschleger, Kevin G.❖

Wisconsin physician named to national health post

David Kindig, MD, of Madison, has been named chair of the federal Council on Graduate Medical Education, giving him a key role in establishing the policies that will determine how many physicians will be trained in the nation, what specialties those students will study and where newly trained physicians should practice.

In addition to his work on COGME, Kindig is a senior advisor to Secretary of Health and Human Services Donna Shalala and director of the programs of health management of the University of Wisconsin Medical School. Kindig is also a member of the Prospective Payment Review Commission, which advises Congress on Medicare policy.

Kindig will continue to divide his time between working in Washington and teaching in Madison.❖

Medical inflation hits 20-year low

The consumer price index (CPI) released by the Bureau of Labor and Statistics shows medical inflation to be at a 20-year low--growing just 5.4% in 1993. This growth includes a 7.8% increase for hospital charges and 5.1% for physician services.

Overall health spending is still projected to grow 12% in 1994, breaking the $1 trillion barrier for the first time.❖

The use of practice guidelines in Wisconsin for liability protection

Charles E. Burroughs, JD, Milwaukee

THOUGH NOT LABELED as such, clinical practice guidelines have been used by physicians for decades in making clinical decisions, and have been formally endorsed by the AMA since 1989. As more states enact practice guideline laws and the current proposals in President Clinton's and Senator Chaffee's bills codifying the use of guidelines on the federal level are debated, physicians will need to decide what side of the debate, if any, they are going to support. Charges by some that guidelines will promote "cookbook medicine," and by others that they are a fail-safe mechanism to halt the runaway train of medical malpractice liability, represent the two poles of this controversy. This paper discusses some of the current issues surrounding this debate and is intended to be an aid or "practice parameter" for analyzing the applicability of a specific guideline in a given circumstance.

Some physicians are concerned that the evolving uses of clinical practice guidelines may lead to increased malpractice liability. Such fears are based on the decisions of some courts in the past few decades that have expanded the legal duties of the physician. A court's review is retrospective, resource expansive, and often appears to penalize physicians for not following treatments which, only with the benefit of hindsight, could have avoided injury to the patient.

An example is *Helling v Carey*, in which the court expanded the acceptable standard of care on the basis that the test for detecting glaucoma was cheap, safe, and accurate, notwithstanding that the customary practice was not to test patients younger than 40. While this remains an unusual and controversial decision, it symbolizes the reason for physician apprehension over potential litigation.

Physicians fear expansion of liability and "the moving standard." One of the announced purposes for using guidelines is to calm these fears. Valid practice guidelines are not only likely to improve the quality of care but could become a dynamic, positive force in curtailing malpractice liability suits in Wisconsin.

Charles E. Burroughs

Standard of care

Currently, physicians owe a duty to their patients to provide the degree of care, skill, and judgment usually exercised in the same or similar circumstances by the average physician who is a general practitioner having due regard for the state of medical science at the time the patient was treated. If a physician is a specialist, then the comparison is with an average specialist practicing that specialty.

A physician also has a duty to provide patients with adequate information on which to make decisions about their medical treatments.

Clinical practice guidelines should neither create new liabilities for physicians nor increase exposure to already existing liabilities. At trial, both the patient and physician introduce evidence through the testimony of expert witnesses in support of the standard they believe applicable. The standard for the particular case is ultimately determined by the jury after weighing all the evidence regarding the standard of care, of which a guideline may constitute only a part.

Clinical practice guidelines can help define what the standard of care is and what is expected from physicians. Guidelines should also make informed consent easier because most, if not all, the background information to be given to the patient is set forth in the practice guideline.

Guidelines should also contribute to fairer outcomes in litigation for both physicians and patients, because a valid or "reliable" guideline should be a tool that provides a basis for semi-objective measurements of the conduct required. This, in turn, will allow judges and juries

Continued on next page

Burroughs is a partner in the Milwaukee office of the Hinshaw & Culbertson law firm and concentrates his practice in health care law. Reprint requests to: Chalres E. Burroughs, Hinshaw & Culbertson, 100 E Wisconsin Ave, Suite 2600, Milwaukee, WI 53202-4115. Copyright 1994 by the State Medical Society of Wisconsin.

Continued from preceding page
to better understand and evaluate the standard of care. All involved--physicians, patients, attorneys, and the reviewing authorities--will have access to not only the same information, but to the more important information. Such knowledge should lead to a level playing field with more predictable results.

A major concern of physicians is that if a physician deviates from a practice guideline this will constitute evidence of medical malpractice. This may or may not be so. If the physician identifies reasons that recommendations in a practice guideline would not be helpful, or indeed why those recommendations may be harmful to a patient, he or she is required by law to follow such medical judgment. If the logic involved in this deduction is followed to its end, a more appropriate standard of care based on the patient's need results. If the physician deviates from a guideline or determines a different standard of medical care is required, the physician should document that decision and its rationale in the patient record. A physician may indeed be liable for not deviating from a guideline where the circumstances mandate deviation. A guideline will not become a mandatory standard of care, absent the enactment of a special law making it so.

Multiple guidelines

The use of practice guidelines in determining the appropriate standard of care is made more complex by the fact that multiple guidelines on the same clinical subject are being issued from different, respected sources. For example, there are two guidelines on the treatment of depression, one by the American Psychiatric Association and one by the Agency for Health Care Policy and Research of the US Public Health Service. Until there is a central body that screens and rates guidelines for appropriateness and excellence, physicians will be confronted with conflicting guidelines and will need to follow the one the physician believes best serves the patient's needs.

In this regard, a physician does not guarantee a correct diagnosis or good outcome, and will not be liable for an honest mistake of judgment, where the proper course is open to reasonable doubt. Following one accepted practice guideline over another should not lead to liability where both guidelines are applicable, both are valid, and both are intended for clinical use. Again, good documentation of the decision and the rationale, if practical, in the patent record is recommended.

Physicians need to familiarize themselves with where to obtain information on guidelines. They also should be in a position to evaluate whether a guideline meets the medical standard of care based on its appropriateness to the facts of the case, the guideline's clinical and scientific value, the method used to develop the guidelines, and the purpose behind the guideline. Continuing education through review of medical literature, seminars, and in-service opportunities will be cornerstones for staying abreast of changes and avoiding liability. Appropriate administrative support services, including access to computerized data banks, will become more valuable for avoiding complications.

Physicians should recognize two important points. First, there is currently no single accepted definition or standard methodology used for the development or evaluation of practice guidelines. Each physician must individually assess applicable guidelines to determine if they meet that level of care necessary and expected under the given circumstances. There are both good and bad guidelines.

Second, guidelines are skewed to their intended purpose. For example, a guideline written for economic considerations may not include all valid treatment options. The physician needs to ascertain the purpose behind a guideline when making a medical decision; the guideline may not rise to the standard of care required if it is not intended for clinical application.

The purpose behind a guideline can have serious ramifications for physicians, especially if that purpose is economic constraint. If guidelines are developed around economic considerations, and they are used for arriving at a clinical judgment, the physician may be liable if a patient is injured as a result of substandard care.

Economic considerations

Physicians are having to make more and more medical decisions based on economic considerations. An example is when a third-party payor denies payment for a treatment or procedure prescribed. This places the physician in a precarious situation. The physician feels the treatment is necessary, but the patient is unlikely to be able to afford treatment. This leads the physician to the choice of risking liability or rendering free care.

Such a situation arose in *Wickline v State of California*, where a patient sued the payor for premature discharge from the hospital which led to the amputation of the patient's leg. The court found that the standard of care was met, but issued a strong policy statement that physicians bear the responsibility of medical treatment decisions; the standard of care must be based on medical judgment, not on economic decisions by third-party payors.

If confronted with a *Wickline* scenario, there are pro-active steps that physicians can employ to minimize their exposure to liability if their patient's payor denies treatment.

- Follow the payor's administrative appeal process. Request a review by a qualified physician in the field and establish a dialogue.

Continued on page 72

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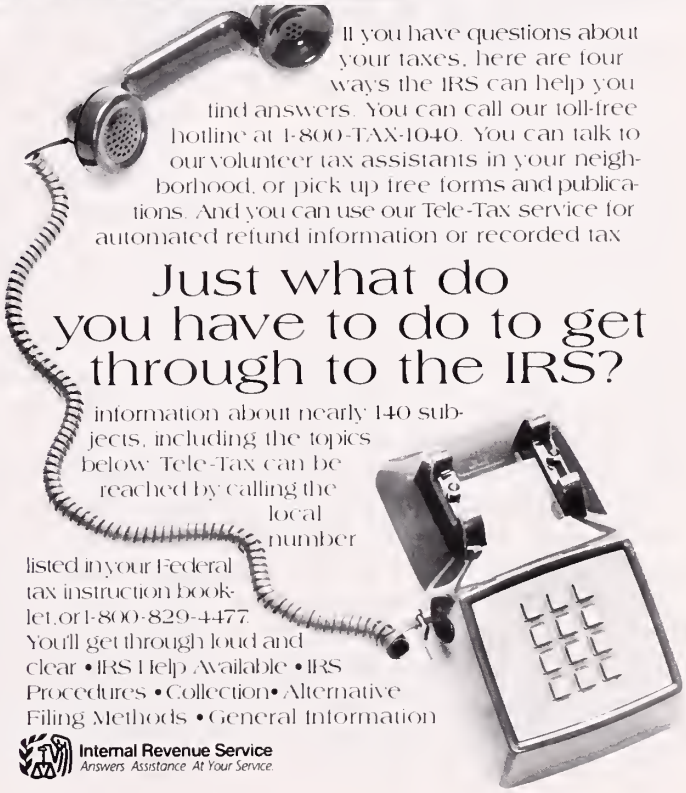

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Continued from page 70

Document in the patient's record the rationale for the desired treatment, the date and time of contact with the payor or reviewer, and the outcome of that communication.

- Inform the patient of the treatment deemed necessary, the rationale for that decision, and the cost involved. Inform the patient of alternative treatment options, if any, and their effectiveness and the rationale of the payor for denying payment.
- Ultimately, make medical decisions and recommendations based on the proper standard of care.

Health care reform

While the concern over rising medical costs may change public policy by allowing economic considerations to become more determinative, that is not how the standard of care is now determined in a court of law.

It is undeniable that physicians are being pressured to compromise their medical decisions to meet economic realities. Some in the health care industry and health care reform movement recognize the need to insulate physicians from liability arising out of diminishing fiscal resources. Health care reformers, such as those involved in the presidential task force, are advocating that compliance with clinical practice guidelines should be an affirmative defense which works as a safe harbor. By elevating practice guidelines to the status or equivalent of a quasi standard of care determined as a matter of law, they believe health care cost savings will be achieved. Proponents of this measure are closely watching Maine's Medical Liability Demonstration Project, enacted in 1990, as well as experiences developed under statutes enacted by Florida, Minnesota, and a number of other states.

The Maine project

The Maine project developed from a desire to control rising medical costs. The practice of defensive medicine was identified as an area where change could be effected by using practice guidelines to encourage medically necessary procedures and to eliminate physician liability in specific areas of medical practice.

The project involves four specialty areas of medical practice: obstetrics and gynecology, emergency medicine, anesthesia, and radiology. Guidelines were adopted and adapted from national guidelines for each specialty. A key component of the project is that participating physicians have a "safe harbor"--an affirmative defense--in using certain practice guidelines. Such an affirmative defense essentially bars any negligence claim connected to medical practice under an appropriate guideline if the physician can prove his or her actions complied with the guidelines. Additionally, the project allows only the defendant physician to introduce the project's guidelines as evidence; this measure is seen as an incentive for physicians to use and develop guidelines. Obviously, there are many trial lawyers who feel this practice is unfair to plaintiffs.

In Florida, some trial lawyers are predicting that practice guidelines will not have much of an effect on medical malpractice verdicts. They believe guidelines will be easily circumvented by simply retaining an expert witness to testify that a particular guideline is inapplicable to the specifics of the case.

Some trial lawyers, including some in Wisconsin, believe that the real action--large jury verdicts--will most likely continue to be in cases that are not prone to coverage in a guideline because the issues are so new and the medical theories so complex they do not easily lend themselves to guideline coverage. There probably is some truth in both of these observations.

The Daubert case

Attorneys who conclude practice guidelines won't change the thinking of courts in medical malpractice lawsuits should consult the US Supreme Court's recent pronouncements in *Daubert v Merrell Dow Pharmaceuticals* concerning evidentiary standards governing the admissibility of expert opinions.

Daubert involved allegations that two children were born with birth defects caused by their mother's ingestion during pregnancy of Bendectin, an anti-nausea drug manufactured by the defendant, Merrell Dow Pharmaceuticals (Dow). Dow moved for dismissal on the basis that there was insufficient proof that Bendectin caused birth defects. Conflicting scientific evidence from experts on both sides was offered.

Medical Examining Board elects officers

THE STATE Medical Examining Board has elected a slate of officers for 1994. The board regulates more than 25,000 health care providers statewide, including 16,000 physicians.

James Esswein, MD, a family practice physician from Chetek, was elected board chair; Ann Neviaser, Madison, (public member), vice chair; and Clark Olsen, MD, an orthopaedic surgeon from Washburn, secretary. Both physicians are SMS members.

The Medical Examining Board processes and takes action when appropriate on more than 600 consumer complaints annually received by the state Department of Regulation and Licensing.◆

The trial court ruled for the defendant, Dow, based on an expert's affidavit. The expert had examined all of the published studies on Bendectin and human birth defects, and concluded that maternal use of the drug during the first trimester of pregnancy had not been shown to be a risk factor for human birth defects.

The Dauberts, on the other hand, attempted to introduce testimony of other experts who concluded there was a link between Bendectin and birth defects, using animal studies, chemical structure analysis, and the unpublished "re-analysis" of previously published human statistical studies as the basis for their opinions. The refusal of the trial court to accept the plaintiffs' expert testimony was based on a finding that the experts' opinions were not based upon a generally accepted scientific principle, citing the 70-year old formulation established by the *Frye* case. That case held that expert opinion based on scientific technique is inadmissible unless the technique is generally accepted as reliable in the relevant scientific community.

Justice Blackmun, writing for the majority, concluded that *Frye*'s general acceptance test was replaced by the Federal Rules of Evidence. Noting that the rule that governs expert testimony requires that an expert's testimony relate to "scientific knowledge," Blackmun concluded that trial judges need to decide for themselves whether the "scientific testimony ... is not only relevant, but reliable." Moreover, Blackmun indicated a key question for determining whether a theory or technique is "scientific knowledge," and thus admissible, is "whether it can be (and has been) tested." The court went on to state:

Scientific methodology today is based on generating hypotheses and testing them to see if they can be falsified. Indeed, this methodology is what distinguishes science from other fields of human inquiry.

Continuing, Blackmun concluded that publication (or lack thereof) in a peer-reviewed publication will be a relevant, though not dispositive, consideration in assessing the scientific validity of a particular technique or methodology on which an opinion is premised. The dissent warned that the majority's decision makes trial judges into "amateur scientists" who must decide whether proffered evidence is "scientific knowledge."

Daubert is unlikely to be viewed as a watershed decision that will suddenly change the landscape for

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medical malpractice litigation. If, however, our Wisconsin trial courts take a cue from the underlying tenets of *Daubert* and become more proactive in ensuring that expert testimony is "not only relevant but reliable," the use of valid practice guidelines should become more common. Over time, they could have a substantial effect on medical malpractice litigation in Wisconsin, especially if a valid guideline is used in conjunction with Wisconsin's liberal and unique statute that controls "learned treatises" (Wis Stats §908.03(18)).

Consider for a moment that a practice guideline is a "publication in a peer reviewed journal." Thus, a trial judge needs to only focus on two questions in deciding admissibility: Is the guideline relevant and is the guideline reliable? The former is a relatively easy decision as it is mostly based on common sense. Reliability, or, said differently, the criteria to evaluate the quality, may be a different question. In determining reliability, a trial judge will initially have to screen a guideline or, in the words of Justice Rehnquist in *Daubert*, one of the dissenting jurists, become an "amateur scientist." This statement alone should be interpreted as an open invitation by the judiciary to the medical profession. A credible practice guideline by definition should function as a tool for educating "amateur scientists" such as judges, juries, politicians, and--especially--lawyers.

Until now adjectives like "good," "bad," and "valid" have been used to describe practice guidelines, but a definition has not been provided. This was intentional. The accepted AMA definition is: "strategies for patient management developed to assist physicians in clinical decision making." By design, this definition was intended to be very broad. On the other hand, judges and lawyers alike are famous for drawing fine lines; therefore, as far as they are concerned a definition like the AMA's does not offer much help. Moreover, attempting to further define a valid guideline would be an exercise in futility.

The solution is relatively simple. Physicians should take every opportunity to educate and inform the legal profession what the criteria should be for evaluating a reliable guideline. Those who study the subject quickly learn that guideline development is the product of many forces and includes one or more of the following:

- informal v formal consensus development;
- evidence-based investigation;
- single v multiple practice specialty promulgation;
- reliance on implicit v explicit assessment of scientific evidence; and
- most guidelines reflect the absence or presence of background materials, information about strengths of recommendations and comparisons of alternative choices, to name a few.

There is much out there on the subject, but, as yet, no court has issued a written opinion addressing the required elements for deciding whether a practice guideline is or is not reliable.

Until there is, we recommend that the following questions--developed primarily from an article by Steven H. Woolf, MD, MPH--be used to analyze the elements needed for a reliable guideline:

- Is the guideline's primary focus clearly patient oriented and do other factors such as cost, feasibility, and malpractice concerns come secondary to the analysis of clinical benefits and harms to the patient?
- Is the supporting scientific evidence, published or unpublished "peer reviewed research" and cited therein?
- Are the relied on opinions and rationale of the experts documented?
- Is there an assessment of the benefits and harms associated with the alternative choices?
- Is the use of clinical judgment encouraged and by implication

Business seminar scheduled for Wisconsin physicians

A HALF-DAY SEMINAR for physicians in private practice and hospital-based physicians will be held Saturday, March 19, at the Sheraton Inn-Mayfair in Milwaukee. The seminar is co-sponsored by SMS Insurance Services Inc; Heil Financial Group; Physicians Insurance Company of Wisconsin; Beck, Chaet, Loomis, Molony & Bamberger, SC--attorneys at law; and Kolb Lauwasser & Co., SC--certified public accounts and business advisors.

The seminar is titled "Secure your income: position your practice for a changing health care environment." Topics will include: strategic planning for health care reform and merger mania; fraud and abuse, reimbursement issues and managed care contracting; credentialing, peer review activities, and related risk management issues; and estate and financial planning.

The seminar fee is $50. Reservations are required. For information, call Sara Brunner at (414) 543-2100.❖

"cookbook medicine" rejected?

If the answers to the foregoing are positive, it is likely a trial judge will conclude a practice guideline is reliable and permit its introduction as some but not conclusive evidence. As a caveat, note that the criteria for a reliable guideline--one that is admissible in court under Wisconsin's "learned treatise" doctrine as independent evidence of the proper standard of care--should be developed by physicians for the benefit of patients and not by lawyers for the benefit of physicians. They should, however, be reviewed by qualified counsel.

Summary

It seems many physicians and other health care professionals are reluctant to advocate that the use of clinical guidelines be expanded because of negative experiences with managed care entities that have based their practice guidelines on economic considerations. Those experiences have led to the erroneous belief by some that all guidelines are minimal or substandard. The trend is clear, however, that clinical practice guidelines will be increasingly important not only in courts but also in the management of health care. They are here to stay and they provide the medical profession with an opportunity now more than ever to decide its own destiny in medical malpractice litigation without the need for new legislation in Wisconsin.

Accordingly, physicians should become pro-active at medical staff departmental meetings, in local and national professional associations, and, if necessary, in the political arena to encourage the adoption of valid guidelines--those that meet acceptable medical standards. In this way the risk that practice guideline use will become both the maximum and minimum standard of care will remain only a theory.

While the decision to use clinical practice guidelines is solely up to a physician, he or she should be aware of a guideline's recommendations for any given patient situation. Ideal practice can still be followed by bad outcomes that prompt patients to claim negligence. By choosing a valid guideline and making a reasonable attempt to follow that guideline, a physician has maximized his or her opportunity for both preventing and prevailing in litigation.

If, however, a guideline exists and it is unintentionally ignored, liability is more likely. Thus, it is incumbent on all physicians to stay abreast and, if possible, become involved in the promulgation of appropriate guidelines. Moreover, there should be no hesitancy in speaking out against a potentially troublesome guideline. In this way, the proper standards for the practice of medicine will not be taken from the medical profession by default and relegated to the determination by a legislative body, or worse yet, by a judge or jury. ❖

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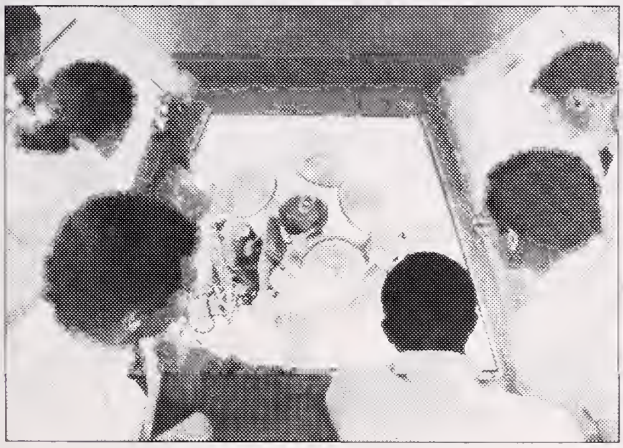

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When Johnny Watts was able to shave himself again, it was a pretty exciting day. But for Joan Dermody, it was equally rewarding. As an occupational therapist for Easter Seals, Joan's average day might consist of helping someone who has had a stroke regain the use of his or her hands. In this case, that meant helping Johnny perform a daily routine that's given him back his independence. His pride. And his sense of humor. Helping people make the most of their abilities is what being an Easter Seal therapist is all about. To Joan and the people she helps, they triumph on a daily basis. ***Give Ability A Chance.***

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Easter Seals

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Nominees for SMS offices: 1994-1995

Marcia J. S. Richards, MD
Nominated for president elect for 1994-1995

Dr Richards received her medical degree from the University of Wisconsin Medical School in Madison and completed an internship and a residency at University Hospitals. A board-certified specialist in radiation oncology, she is currently director of radiation oncology at St Luke's Medical Center in Milwaukee and is a past president of the Medical Society of Milwaukee County. She has also served as secretary-treasurer of the organization and is a past president of the Wisconsin Society of Radiation Oncologists. She is currently the president of the Wisconsin Division of the American Cancer Society, having served as chair of its Breast Cancer Detection Awareness Project and as a member of its board of directors and chair of the Professional Education Committee. She is also vice-president of the Wisconsin Radiology Society, and a member of the Medicare Advisory Committee. Dr Richards has been a delegate to the SMS since 1983.

Marcia J.S. Richards, MD

Cyril M. (Kim) Hetsko, MD

Michael C. Reineck, MD
Nominated for vice speaker of the house of delegates for 1994-1996 (photo unavailable)

Dr Reineck graduated from the University of Wisconsin in 1970 and completed an internship at Milwaukee County General Hospital and a residency at St Mary's Hospital, in affiliation with the Medical School of the University of Michigan, in Grand Rapids. He has been in private practice at Orthopaedic Associates of West Bend, S.C., since 1975. Dr Reineck is chair of the Governmental Affairs Committee, and past president of the Wisconsin Orthopaedic Society and the Washington County Medical Society. He is also a member of the Wisconsin Professional Liability Committee, and the American Academy of Orthopaedic Surgeons ICD-9-CM Coding Committee, Health Care & Financing Committee, and Bylaws Committee. He has been the Washington County Medical Society delegate to the SMS House of Delegates for the past 10 years.

Cyril M. (Kim) Hetsko, MD
Nominated for delegate to the AMA for 1995-1996

Dr Hetsko, a past president of the SMS, graduated from the University of Rochester School of Medicine and Dentistry and completed his internship and residency and was chief resident at the University of Wisconsin Hospitals. He has been a member of the Dean Medical Center since 1975 and is a clinical associate professor of medicine at the University of Wisconsin, Madison. Dr Hetsko is active in the Wisconsin Society of Internal Medicine, serving as president from 1987 to 1988. He is chair of the SMS Task Force on Aids. In addition, he was vice speaker of the SMS House of Delegates; a member of the Task Force

Continued on next page

John P. Mullooly, MD

Richard H. Ulmer, MD

Jerome W. Fons, Jr, MD

on RBRVS, Strategic Planning Committee, and Task Force on Physician Discipline and Review; and served on the SMS Board of Directors for 9 years and was chair of its Finance Committee. He has been a member of the Wisconsin delegation to the AMA since 1983, serving as alternate delegate and current secretary. He is a past chair of the Department of Medicine at St Mary's Hospital Medical Center, in Madison, and was a member of the Medical Staff Executive Committee. He is currently a member of the Infection Control and Pharmacy and Therapeutic committees, as well as a past member of its Institutional Review Board. He has received the Presidential Award from the Dane County Medical Society and the SMS Meritorious Service Award. Dr Hetsko is now a trustee of the American Society of Internal Medicine.

John P. Mullooly, MD
Nominated for delegate to the AMA for 1995-1996

Dr Mullooly has served as alternate delegate to the AMA since 1985 and delegate since 1991. He is currently an editorial associate for the *Wisconsin Medical Journal*. Dr Mullooly served as president of SMS in 1986-1987 and of the Medical Society of Milwaukee County in 1984. He received an SMS Meritorious Service Award in 1985. He served as president of both Milwaukee Academy of Medicine and Catholic Physicians Guild. He has been editor of *Linacre Quarterly* since 1969. Dr Mullooly is a member of the Wisconsin Society of Internal Medicine, the Wisconsin Heart Association, and the American College of Physicians. He received the Addis Costello Internist of the Year Award from the WISM. He has been the vice chair of the SMS Holdings Corporation Board of Directors since 1978. Dr Mullooly graduated from Marquette University School of Medicine and completed his residency at Milwaukee County General Hospital. He has been an assistant clinical professor of medicine at the Medical College of Wisconsin since 1966.

Richard H. Ulmer, MD
Nominated for delegate to the AMA for 1995-1996

Dr Ulmer received his MD and MS in physiology from Stritch School of Medicine of Loyola University, Chicago. He served his internship and residency in cardiology at the University of Chicago Hospital and Clinics. He is a cardiologist at the Marshfield Clinic. Dr Ulmer was president of the Wood County Medical Society in 1978 and 1985. He has been chair of the SMS Board of Directors since 1989 and is a member of the SMS Steering Committee, AMA Forum of Employed Physicians, and SMS Committee for Young Physicians. He has been a member of the AMA Advisory Committee on Group Practice Physicians since 1992, and was an alternate delegate to the AMA for the past 10 years.

Jerome W. Fons Jr, MD
Nominated for alternate delegate to the AMA for 1995-1996

Dr Fons served as the SMS alternate delegate to the AMA since 1988. A member of the SMS since 1964, he served as a member of the SMS Board of Directors from 1981 to 1988 as well as a member of the SMS Physicians Alliance Commission and the Task Force on Medical Liability. He is currently a member of the SMS Commission on Medical Liability. Dr Fons served as president of the Medical Society of Milwaukee County in 1986. He is currently vice chairman, Board of Directors, of Physicians Insurance Company of Wisconsin. In 1989, Dr Fons received the SMS Physician-Citizen of the

Year Award. Dr Fons graduated from the Marquette University School of Medicine and served his internship and residency at St Joseph's Hospital in Milwaukee. He was on the medical staff of Trinity Memorial Hospital, Cudahy, and St Francis Hospital of Milwaukee.

Kevin A. Jessen, MD
Nominated for alternate delegate to the AMA for 1995 and 1996

Dr Jessen graduated from the University of Minnesota Medical School in 1978 and served a family practice residency at Southwestern Michigan Area Health Center in Kalamazoo. He has been employed at the Gundersen-Mubarak Clinic in Tomah since 1982, serving as medical director since 1990. Dr Jessen is a member of the board of directors of the Tomah Memorial Hospital and a past president of the hospital's medical staff. He was the delegate to the Young Physicians Section of the AMA in 1991-1992, and a member of the State Nominating Committee of the SMS in 1990 through 1993, serving as chair in 1991-1992. He was a member of the SMS Special Reference Committee on district representation in 1992, and chairman of the Socio-Economic Reference Committee in 1993. Dr Jessen has been the president of the Monroe County Medical Society since 1987. He served as the county's delegate to the annual state meeting since 1989, and was the alternate delegate in 1987 and 1988.

Robert F. Purtell, Jr, MD
Nominated for alternate delegate to the AMA for 1995 and 1996

Dr Purtell has been a member of the SMS Board of Directors and its Executive Committee since 1989. He was chair of the SMS Federal Legislative Policy Committee from 1977-1985, and a member of the Commission on Governmental Affairs from 1978-1985. He served as the delegate to the House of Delegates, Family Practice Section, and chair of the Physicians Alliance Commission from 1985 through 1989. Dr Purtell served on the Reference Committee on National Issues at the House of Delegates in 1980-1982. He has been a member of the Nominating Committee since 1986, serving as chair in 1989-1990. Dr Purtell has been active in the Wisconsin Academy of Family Physicians and the American Academy of Family Physicians. He served as president of the Milwaukee County Medical Society in 1992-1993 and has been an alternate delegate to the AMA since 1990. He was president and chair of the board of directors of PrimeCare Health Plan of Wisconsin from 1982 through 1986. Dr Purtell graduated from Marquette University in 1961 and served his internship at Misericordia Hospital, in Milwaukee, and his residency at St Joseph's Hospital, in Milwaukee.

Kevin A. Jessen, MD

Robert F. Purtell, Jr, MD

Kevin T. Flaherty, MD
(photo unavailable)

If Richard H. Ulmer, MD, is elected by the 1994 House of Delegates as an AMA Delegate, the committee is prepared to nominate Kevin T. Flaherty, MD, Wausau, as an AMA Alternate Delegate for calendar year 1995

Dr Flaherty received his medical degree from Loyola University in Chicago. He served an internship at Sacred Heart Medical Center in Spokane, Wash, and his residency at Loyola University in ophthalmology. He has been in practice in Wausau for 5 years. Dr Flaherty has served as the Marathon County Medical Society delegate to the SMS House of Delegates. He has also been a member of the Marathon County Medical Society Executive Committee and president elect. He has chaired reference committees at the Young Physicians Section of the AMA and SMS.❖

Celebrate
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Survey to determine interest in SMS electronic bulletin board system

THE 1994 SMS Electronic Bulletin Board Survey was enclosed in the Feb 16 issue of the *Medigram*. The SMS Board of Directors requested this survey during the October 1993 meeting to determine interest in a proposed SMS electronic bulletin board system. In generic terms, a bulletin board system (BBS) is a computer system equipped with one or more modems that serves as an information and message-passing center for dial-up users.

If a BBS is implemented, it will allow SMS members to use their home or office personal computer to communicate with colleagues and staff via electronic mail, gain access to past and current articles from SMS publications, and receive frequent updates on hot topics and events. Please invest a few moments of your time by responding to the survey questions. Surveys must be returned to the SMS by March 16. ❖

SMS annual meeting program on domestic violence

The SMS Task Force on Domestic Violence, chaired by Immediate Past President William J. Listwan, MD, will sponsor a program on domestic violence April 15 during the SMS annual meeting in Milwaukee. Nancy Worcester, PhD, outreach specialist for UW-Madison Women's Studies and coordinator of the Wisconsin Domestic Violence Training Project will speak on "The unique role physicians can play in recognizing and responding to domestic violence." The program will be held Friday, April 15, from 1:30 p.m. to 3:30 p.m. During a panel segment, members of the SMS Task Force on Domestic Violence will discuss experiences in working with victims and offer information on interventions.❖

The charm of Milwaukee is evident in the Pabst Theater, a show-case Victorian theater built in 1895, now featuring top musical and theatrical entertainment. The SMS annual meeting program is in this issue of WMJ.

Children Our Future

Through its **Children: Our Future** campaign, the American Academy of Pediatrics aims to put child health at the top of the healthcare reform agenda.

Every child in America deserves a "medical home"—a place to go for regular, comprehensive healthcare. That's important because preventive healthcare is the key to a healthy child.

The nation's pediatricians and the American Academy of Pediatrics are working to improve healthcare for children. As part of the effort, we've declared October as **Child Health Month**. Join us this month as we speak up for children. Help us place solutions before problems.

- **Before it's too late, vaccinate.** Check your records. Immunize your child on time.
- **Give your home a safety check.** Ask your pediatrician about childproofing tips. Most injuries are preventable.
- **Combat substance abuse.** Don't allow smoking around your children. Don't let friends drink and drive.

For a free list of more ways you can help, send a stamped, self-addressed envelope to: *Children Our Future*, Dept. C, American Academy of Pediatrics, P.O. Box 927, Elk Grove Village, IL 60009.

American Academy of Pediatrics

Book review

The Life and Times of a Country Doctor

Shari Hamilton, assistant editor

Hath not the potter power over the clay, of the same lump to make one vessel unto honor, and another unto dishonor--Romans 9:21

"He is the potter; I am the clay." To some the words of that traditional Christian hymn are readily sung but quickly forgotten. To others, like James Albrecht, MD, they are a creed.

Farm boy. Physician. Drop-out. Christian. Dissenter. Potter. Activist. Teacher. Author. Taken together, those terms could be used to sum up James Albrecht's, life in ten words or less. But such a crisp summation would not do justice to the remarkable lifetime journey of this uncommon Wisconsin physician, a past recipient of the SMS Physician Citizen of the Year award, nor would it provide opportunity for readers to discover why many of the people whose lives Albrecht has touched favor an even more concise description of this man: "friend."

"... a compelling delivery well mixed with humor and drama..."

In *The Life and Times of a Country Doctor*, a paperback autobiography published in 1993 by DeRaimo Publishing of West Bend, Albrecht traces for his readers his footfalls on the road less traveled, his journey of faith. Chronicled here are his early impressions as a Wisconsin farm youth working with the threshing crew, the poverty that forced him to drop out of high school to support his family, and the determination that led him to complete his studies and go on to enroll at the University of Wisconsin-Madison campus in the days when a UW student's annual expenses, including tuition and books, totaled an now-unbelievable $336.85.

In a compelling delivery well mixed with humor and drama, Albrecht provides fascinating perspective on the many social changes that have transpired in Wisconsin over the past eight decades. His autobiography looks at the state's transformation from an agrarian economy and discusses peaks and pitfalls in the progress of both farming and medicine.

Albrecht relates the resolute beliefs and ideals that compelled him to become the first medical student in the United States to become drafted due to his insistence on being known as a conscientious objector to war. His decision drew much criticism from neighbors and associates.

Albrecht established his general medical practice in Jackson, receiving his first patient Aug 6, 1948. Demonstrating a small town familiarity typical of Wisconsin's earlier years, the patient, who had broken his arm 4 hours earlier, stopped off at the post office to make sure "Doc's" license had arrived in the mail before he sought Albrecht's help.

Prompted by his strong religious beliefs, Albrecht has felt obliged to do more than identify needs within his community; he has worked to see that these concerns are addressed. With no ambulance service in town, for example, to transport victims of motor vehicle accidents, Albrecht converted a station wagon for that purpose, outfitting the vehicle with a folding cot and a receptacle for an oxygen tank. He then volunteered his own services as driver. (The sheriff's department, by the way, welcomed his initiative, swearing him in as a deputy so he could be eligible for a siren and warning lights.) Albrecht supplied this valuable mobile health care service for many years before others could be persuaded to take on the role.

James Albrecht, MD

A relative's experience with alcoholism induced Albrecht to become involved with the United Temperance Movement and lobby against the beer industry. With the help of members from Hartford and Milwaukee, he went on to establish the first Alcoholics Anonymous program in his area; he steadfastly

Continued on next page

Continued from preceding page
worked to generate support for the program among community residents. In 1970, Albrecht expanded his efforts to include support groups for people with drug dependencies.

Ever the activist, Albrecht has battled the bureaucracy over unfair Medicaid and Medical Assistance regulations, taking his cause to the state capitol and Congress. He details those sometimes-heated exchanges in a chapter titled, "Tilting at Windmills."

In 1970, he exercised his rights as citizen of a democracy in quite a different way--leading his Sunday school class in an effort that brought about the return of our National Day of Prayer.

After practicing medicine for nearly 5 decades, on Jan 1, 1994, Dr Albrecht announced that he was expanding his semi-retirement status to the point where he would only see patients by appointment two or three mornings a week at the Jackson office of the General Clinic.

> "Albrecht traces his foot falls on the road less traveled, his journey of faith."

This new arrangement will leave him more time for other pastimes. The physician-author teaches pottery to community classes, passing on to others a passion for the clay that he discovered back in the 1960s when his wife encouraged him to find an interest beyond practicing medicine 18 hours a day.

Marian, his wife of 48 years, edited the first 17 chapters of Dr Albrecht's book before her death in December 1992. Marian was an accomplished painter, capturing charming Wisconsin scenes with her watercolors. A pull-out section of the book offers readers a sampling of her art.

Continuing his lifetime practice of stewardship, Albrecht has directed that proceeds from *The Life and Times of a Country Doctor*, as well as prints of six of Marian's paintings and notepaper, be given to Lutheran Social Services to support community outreach efforts in Wisconsin. To order, send a check for $23.45 to Jim Albrecht, 2487 Pleasant Valley Road, Jackson, WI 53037. *Photo by William L. Stonecipher, West Bend.*✦

Physician briefs

The * indicates a member of the SMS.

Avi Bar-Lev, MD, a specialist in oncology and hematology, has begun seeing patients at the Ripon Medical Center Outpatient Clinic. Dr Bar-Lev is affiliated with Fox Valley Hematology and Oncology in Appleton. He received his medical education at the University of Bologna, Italy, and completed an internship and residency in internal medicine at Sinai Hospital in Detroit. He also completed a fellowship in hematology and oncology at Detroit's Henry Ford Hospital. He is board certified.

Kathryn Brimhall, MD,* a psychiatrist, has joined the clinical staff of Northshore Clinic of Sheboygan. Dr Brimhall had previously served as medical director of Northshore Clinic and is now closing her practice to return to the clinic full time. In addition, Dr Brimhall serves on the board of directors of the Mental Health Association of Sheboygan County.

Robert A. Cavanaugh, MD,* has been named president of Bellin Hospital's medical staff in Green Bay. The obstetrician-gynecologist will serve a 2-year term. Others on Bellin's executive committee include: **Dr Thomas Geocaris,*** vice president, and **Dr Michael McHenry,*** secretary.

Richard Cooper, MD,* executive vice president and dean of the Medical College of Wisconsin, has announced his decision to step down as the MCW dean, effective Sept 1. At that time, Dr Cooper will take a brief sabbatical before returning to direct the MCW Health Policy Institute.

Paul Kaesberg, MD,* a member of Physicians Plus Medical Group's oncology and hematology department, is now treating patients at Memorial Hospital for Lafayette County in Darlington. Dr Kaesberg is board certified in internal medicine and hematology.

Joav Kofman, MD,* has begun treating patients at Memorial Hospital of Lafayette County. Dr Kofman will join Physicians Plus neurologist **Anne Weiss, DO,** who currently sees patients in Darlington. A graduate of Chicago Medical School, Dr

Kofman completed his residency at Rush-Presbyterian-St Lukes Medical Center in Chicago. He recently completed a fellowship in EMG-neuromuscular disease-movement disorders at Bowman-Gray Medical Center in Winston-Salem, NC.

Richard A. Leer, MD,* has been re-elected to serve his fourth term as president of the Marshfield Clinic. Dr Leer is a family practice physician. Also re-elected to the executive committee were: **Dr Michael J. Kryda,*** a pulmonary specialist, vice president; **Dr Dean T. Strueland,** an emergency medicine specialist, treasurer; and **Dr Robert K. Gribble,*** an obstetrician-gynecologist, corporate secretary.

Stephen G. Meres, MD, medical director of emergency medicine at St Agnes Hospital in Fond du Lac, has been elected to a 2-year term on the board of directors for the Wisconsin Chapter of the American College of Physicians. Dr Meres completed his residency at Marshfield Clinic. He is board certified.

Continued on next page

Ulmer, Newcomer to serve on AMA advisory committee

RICHARD H. ULMER, MD, of Marshfield, and Kermit L. Newcomer, MD, of La Crosse, have been appointed by the AMA Board of Trustees to serve 2-year terms on the Advisory Committee on Group Practice Physicians.

The two Wisconsin physicians were notified of their appointments in a Dec 15 letter from AMA Executive Vice President James Todd, MD.

Nine physicians and one non-physician administrator serve on appointed seats on the advisory committee. In addition, there are five slotted seats for the delegate and alternate delegate of the American Group Practice Association and the observer to the Medical Group Management Association. The EVP of the AGPA and the executive director of the MGMA serve as ex officio, non-voting members.◆

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AIR FORCE

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James J. Nicholson, MD,* has joined the anesthesia staff of Sheboygan Medical Center. A Milwaukee native, Dr Nicholson earned his medical degree from the University of Wisconsin. He was board certified in surgery in 1991.

Christopher J. Ostromecki, MD,* recently joined the medical staff of the Monroe Clinic. A cardiologist, Dr Ostromecki completed his residency training in internal medicine at Overlook Hospital in Summit, NJ. He then completed a fellowship in cardiovascular diseases at the University of Medicine and Dentistry of New Jersey and Beth Israel Hospital in Newark, and at the Veteran's Administration Medical Center in East Orange.

Joseph W. Rucker, Jr, has joined the outpatient clinic staff at Bloomer Community Hospital. Dr Rucker's practice will focus on both cosmetic and reconstructive surgery. Dr Rucker completed his medical training at the Michigan State University College of Human Medicine in East Lansing. His general surgery training was accomplished at Mount Carmel Mercy Hospital in Detroit, followed by his plastic surgery training at Wayne State University, also in Detroit. He is board certified.

Konrad Soergel, MD, professor of medicine and physiology, and an international expert in gastrointestinal fellowship program and coordinator of the department of medicine's fellowship program at the Medical College of Wisconsin. Dr Soergel will coordinate all gastroenterlogical research and post graduate programs.

Monty Woods, MD, has joined the medical staff at the Memorial Hospital of Iowa County. Dr Woods earned his medical degree from Wake Forest University in North Carolina before completing surgical residencies in Boston and Washington, DC. Dr Woods practiced in Hawaii prior to relocating to Wisconsin.◆

County society news

Brown. The Brown County Medical Society met in Green Bay at the Holiday Inn City Center Nov 11, 1993. The topic of discussion was a health plan for Brown County. New members accepted were James Dibdin, MD, and William Dierberg, MD.

The Brown County Medical Society met Jan 13, 1994, at the Holiday Inn City Center in Green Bay. Michael Bolger, JD, president of the Medical College of Wisconsin, was the guest speaker. New members accepted into the society include: Lindy Eatwell, DO; Neil Fullan, MD; Paul Holzman, MD; Thomas Huffer, MD; Daniel Koster, MD; Donald Sipes II, MD; Scott Westenberg, MD; Richard Erdman, MD; Michael K. Case, MD; Michael P. Darnell, MD; and Henry K. Feider, MD.

Dane. New members accepted into the Dane County Medical Society are: Kathryn Balough, MD; Blayne Fritz, MD; Glenn Jarrett, MD; Kathy Kowalke, MD; William Miller, MD; Leslie Taylor, MD; and David Zeman, MD.

Eau Claire-Dunn-Pepin. The following physicians were accepted into membership in the Tri-County Medical Society: Saleh A. Obaid, MD; Kenneth Richard Mitchell, MD; Perry L. Kyser, MD; Gail Ann Tasch, MD; Derek A. Scammell, MD; Michael John Murray, MD; Kirk Victor Dahl, MD; Robert Curtiss Peck, MD; Steven M. Kapla, MD; John E. Agens, MD; David L. Castleberg, MD; Lisa M. Gillette, MD; Mark Charles Steinmetz, MD; Lorene L. Vedder, MD; Mark W. Chang, MD; Erik J. Dovre, MD; Peter C. Nishan, MD; Ronald P. Seningen, MD; Mark Attermeier, MD; William C. Granger, MD; Stephen William Noltner, MD; Heide Telfer Klessig, MD; Nathan E. Smithberg, MD; Nancy M. Sahakian, MD; Philip Michael Gilberstadt, MD; Suzette K. Peltier, MD; David F. Powell, MD; Robert L. Dohlman, MD; Thomas P. Nobrega, MD; Michael Terry McEnany, MD; Alon Coppens, MD; Donn D. Dexter, MD; and Patrick J. Hughes, MD.

Fond du Lac. The Fond du Lac County Medical Society met Oct 28, 1993, at the South Hills Country Club. New members approved are Glen Joseph Kemp, Jr., MD, and Charles E. Larson, MD.

Grant. The Grant County Medical Society approved the membership of Anthony Gausas, MD.

Green Lake-Waushara. The Green Lake-Waushara County Medical Society approved membership for Ross A. Hazelwood, DO, and Mercedes P. Schaafsma, DO.

Jefferson. The Jefferson County

Medical Society approved membership for the following physicians: Donald E. Bates, MD; Satwant S. Dhillon, MD; John A. Ferris, MD; Billie G. Kontny, MD; Jeanne N. Larson, MD; James A. Milford, MD; Cecilia M. Multhauf, MD; Milton L. Pozo, MD; Moazam J. Samdani, MD; Benjamin T. Schmidt, MD; Thomas J. Tackman, MD; and Brett A. Wilson, DO.

Kenosha. The following physicians were approved for membership in the Kenosha County Medical Society at the general membership meeting held Nov 11, 1993: Mary C. Mason, MD; Victor S. Slana, MD;Linda J. Meyer, DO; and Ismael R. Sta Romana, MD.

Marinette-Florence. The Marinette-Florence County Medical Society approved membership for Jagdev R. Bhatoya, MD, and Gian C. Daroach, MD.

Milwaukee. The following physicians have been approved for membership in the Medical Society of Milwaukee County: William Robert Fleming, MD; Richard L. Franklin, MD; Barbara Ann Harkness, MD; Gail E. Hendley, MD; Afam C. Ikejiani, MD; Eric W. Kaplan, MD; Susan D. Kretzschmar, MD; James D. Lincer, MD; Charles James Locher, MD; Anthony P. Maresca, MD; Richard N. Schmidt, MD; Ernest S. Stremski, MD; Jill Parker Wohlfeil, MD; Jose Singson Abad Santos, MD; Maninder Singh Atwal, MD; Pradeep Bansal, MD; John Thomas Batter, MD; Laura Marie Cantwell, MD; Richard E. Carballo, MD; Gregory Joseph Capelli, MD; Dwayne Thomas Capper, MD; Steven Scott Carp, MD; Thomas Gerard Castellano, MD; Denis Flores Castillo, MD; Andrew Un-Song Chai, MD; Ellen Hui-Chin Chen, MD; Asriani Marisa Chiu, MD; Brian G. Cuddy, MD; Sharon Marie Curtis, MD; Marian Angeles Franco Del Rosario, MD; Constance Rose DiAngelo, MD; Suzana Ivanov Dudley, MD; Abdul G. Durrani, MD; John Allen Feilbach, MD; Alfredo Dante Fernandez, MD; James M. Garrity, DO; Laurie E. Gossard, MD; Christina E. Hantsch, MD; John G. Heisdorf, MD; Michael Richard Hold, MD; Jeanne Ellen Hryciuk, MD; Maria Gina Ilao-Pahn,MD; Mazen Kherallah,MD; Deborah L. Kim, MD; Patrick G. Krismer, MD; Peter Langenstroer, MD; Robert Osborn Lindsey, MD; Reuben Nicholas Lubka, MD; Michael F. McBride, MD; Susan Martha Malinowski, MD; John Gregory Markley, MD; Adrian Aron Matioc, MD; Kathleen Y. Moen, MD; Colleen Mary Nichols, MD; Rebecca Jo Palmberg, MD; Steven Michael Patalano, MD; Dennis B. Phillips, DO; Christine Marie Poulos, MD; Srutha Paka Rajkumar, MD; Robert J. Rawski, MD; Leanne Louise Richardson, MD; Michael W. Romeo, MD; Inell C. Rosario, MD; Eduardo A. Ruan, MD; Ann E. Ruscher, MD; Lonie R. Salkowski, MD; Frank J. Salvi, MD; Kurtis D. Scheer, MD; Andrew J. Schroettner, MD; Karen Sue Seligmann, MD; Jeffery R. Smale, MD; Grigory Sorokin, MD; Joan L. Stetzer, MD; Bruce Robert Stevens, MD; Amy J. Stolarski, MD; Kevin B. Strom, MD; Tuyen Thanh Tran, MD; Joshua H. Urvater, MD; Steven James Vacek, MD; Ilya B. Volfson, MD; Mary Dennehy Washburne, MD; William V. Walters, MD; Barry N. Wilcox, MD; Nick Zarkos, MD; Anita M. Arnold, DO; Steven R. Berquist, MD; Rochelle P. Eissenstat, MD; Raymond A. Hansen, MD; Greg Heal, MD; Stephanie M. Hernandez, MD; Terry Jakubaitis, MD; Steven C. Johnson, MD; George F. Kessler, MD; Mark A. Lindstrom, DO; Cheryl Renee Martin, MD; Henry Notardonato, MD; Sear T. O'Brien, MD; Cynthia L. Palabrica, MD; Miodrag M. Popovich, MD; Joseph M. Puccinelli, MD; Jeffrey K. Reichel, DO; Paul Edward Robey, DO; Mark P. Rollins, MD; Basil M. Salaymeh, MD; Lucy Stone, MD; John E. Watt, MD; Dwight A. Wigg, MD; Thomas R. Wigton, MD; Cory A. Wilson, MD; Sandra R. Bates, MD; Marcie G. Berger, MD; Nancy A. Boelter, MD; John E. Cantrell, MD; Diana M. Chen, MD; Famin Chou, MD; Marguerie R. Compton,

Continued on next page

SMS commission to sponsor program on medical liability

The SMS Commission on Medical Liability and Risk Management will present an update on medical liability Friday, April 15, during the 1994 SMS annual meeting in Milwaukee. Gordon H. Smith, JD, executive vice president of the Maine Medical Society, will kick off discussion with his presentation on "The Maine medical liability demonstration project: a guide to practice parameters."

Joseph M. Fasi II, JD, from the firm of Hinshaw & Culbertson, also a member of the American College of Legal Medicine, will follow with advice on "How to lose a suit." Smith and Fasi will then form a panel with Joseph Di Raimondo, MD, and Sidney Johnson, MD, members of the SMS Medical Liability and Risk Management Commission, to answer queries and concerns from the audience. Don't miss this opportunity to connect with the experts on these up and coming issues.

Please see related article on page 69 of this *WMJ*.❖

Continued from preceding page
MD; Dawn DeJager, MD; Silvia DePaz, MD; Carol M. Gaines, MD; Robert C. Hardie, MD; Kathleen Conway-Jurell, MD; Kim R. Jurell, MD; Thomas Knickelbine, MD; Thomas G. Kraemer, MD; Jacqueline J. Krumrey, MD; Ellen Margaret Leeney, MD; James S. Linder, MD; Melinda L. McCord, MD; Martin F. McGough, MD; Stuart P. Michelson, MD; Arthur F. McInar, MD; Andrea Lynn Munoz, MD; Robert W. Nash, MD; Susan R. Oneson, MD; Randal K. Ruvalcaba, MD; Kia Saeian, MD; Zaki Samman, MD; Andrew Satinsky, MD; John E. Schaeffer, MD; Susan Schloff, MD; Michael Y. Seiba, MD; Lynn M. Stanco, MD; Eric Todd, MD; Myrosia M. Tomiak, MD; John S. Walsh, MD; Deborah L. Wollad, MD; and Benjamin S. Yabut, MD.

Oneida-Vilas. The Oneida-Vilas County Medical Society met in Rhinelander Nov 16, 1993, at the Claridge. Sally Wencel, SMS staff, spoke on medicine in transition. New members approved are Christopher J. Cold, MD, and Jennifer Norvell-Cold, MD.

Ozaukee. On Jan 20, 1994, Robert Arfman, MD, was elected to membership in the Ozaukee County Medical Society.

Racine. The Racine County Medical Society approved membership for Thomas A. Graul, MD.

Richland. Paula M. Strait, DO, has been accepted for membership in the Richland County Medical Society.

Rock. The Rock County Medical Society approved membership for the following physicians: Shih-Wen Chang, MD; Steven E. Diebold, MD; Michael A. Donnelly, DO; Rosa A. Gilestra, MD; Raymond H. Holderman, DO; Leighton H. Javid, MD; Kenneth L. Klein, MD; Jay C. Klemme, MD; Susan E. Montgomery, MD; Anna Maria Myklebust, MD; Carol J. Neuman, MD; Anthony W. Phillips, MD; Emilio J. Rodriguez-Viera, MD; Lawrence M. Shea, MD; Michael Simanovsky, MD; Ronald S. Sokovich, MD; Michael J. Strassman, MD; Thom S. Thomassen, MD; Kanchana R. Viswanathan, MD; Bohdan K. Wasiljew, MD; and Michael K. Wood, MD.

Sauk. The Sauk County Medical Society approved membership for the following physicians: Christopher W. Cervantes, MD; William R. Degelman, MD; Michael J. Fitzgerald, MD; Mary Ellen Sabourin, MD; and Daniel D. Trotter, MD.

Sheboygan. The Sheboygan County Medical Society elected the following physicians into membership: Bryan Schmitt, MD; Jill Schmitt, MD; Charles Schleevogt, MD; F. Andrew Bock, DO; and Akhtar Parvaiz, MD.

Taylor. The Taylor County Medical Society approved membership for Manuel C. De Leon, III, MD and Brent L.Gunsolly, MD.

Waukesha. The Waukesha County Medical Society approved membership for David R. Fisher, MD.

Waupaca. The Waupaca County Medical Society approved membership for Gregory J. Hunter, MD, and Tomasz K. Miaskowski, MD.

Winnebago. The Winnebago County Medical Society approved membership for the following physicians: Martin Sabatinos, MD; Jeffrey R. McLaughlin, MD; Mary McDonald, MD; and Caroline McDonald, MD.❖

Medical student program sponsors sought

MORE MEDICAL STUDENT sponsors are needed, according to Anne Rittman, SMS manager of membership development. The SMS is looking for physicians who are interested in sponsoring a medical student financially for membership in the state and county medical societies and the AMA so that he or she may become involved in organized medicine early in his or her professional development.

The cost to sponsor a student is minimal, $32.50 for one year or $118 to sponsor a student for all four years of medical school. If you would like to help medical students get involved, call Rittman at 1-800-362-9080 or (608) 257-6781 (in Madison) to learn more about becoming a sponsor.❖

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American Heart Association

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New guidelines on HIV, nicotine released

THE AMA HAS released new early intervention guidelines for the treatment of HIV as well as guidelines on the diagnosis and treatment of nicotine dependence.

The new HIV guidelines will help physicians diagnose HIV infection, determine the disease stage, monitor and treat during the early stages of the infection and assist patients in modifying behavior that can transmit HIV. An estimated 1 million Americans are infected with HIV disease.

The AMA has also released new smoking cessation guidelines, giving physicians a step-by-step approach for implementing a "stop smoking" program for patients. Smoking and exposure to passive or environmental smoke kill 500,000 people a year. In addition to loss of life, cigarettes cost $68 billion in health care and insurance as well as causing lost productivity.

The National Cancer Institute reports that more than 70% of the 45 million US smokers will have at least one office visit with a primary care physician this year.

"Patients regard their physicians as an important, credible source of information," said SMS President Pauline M. Jackson, MD, of La Crosse. "Studies show that patients who are urged by their physicians to reduce tobacco use are much more likely to quit smoking than those who lack this vital contact. Encourage your patients who smoke to quit, and provide them with information about smoking cessation programs."❖

Racine, Milwaukee, and Rock counties hold mini-internships

SEVERAL WISCONSIN county medical societies and their alliances have reported excellent mini-internship experiences. The Racine County Medical Society, in conjunction with the Racine County Medical Auxiliary, conducted a mini-internship program Oct 11-12, providing an opportunity for participating community leaders to accompany physicians throughout the course of a 2-day period and observe the full scope of each doctor's ordinary activities. Local leaders participating in the program included: Rev Jim Peters, of the Immanuel Lutheran Church; Tim Bowers, managing director of MEI, Inc.; Garvin Shankster, senior vice president of human resources for S.C. Johnson; and Dan Bostedt, corporate manager of health benefits for Snap-On Tools. Each person spent a half day with four physicians in various medical settings, including an emergency department, surgery, and hospital care. Gregory Shove, MD, and Jeri Cushman directed the program.

The Medical Society of Milwaukee County held its second successful mini-internship Oct 12. Eight interns participated, representing media outlets, medical society staff, and health policy experts from the community. Each intern observed both primary care physicians and specialists. At the debriefing dinner, many of the interns indicated that the experience allowed them greater insight into the problems facing the health care delivery system. Many participants observed defensive medicine, patient abuse of the system, and the results of unhealthy lifestyles. Carl S.L. Eisenberg, MD, James E. Youker, MD, Betsy Aguilar, Judy Paz and Pat Aschliman were among those contributing to the program's success.

Held Aug 8-10, the Rock County Medical Society's mini-internship program drew 14 community, civic, and legislative leaders with more than 30 physicians participating as mentors. Interns represented General Motors, Blue Cross and Blue Shield, the Janesville *Gazette*, Janesville Fire Department, Wisconsin Cost Containment Commission, Yoemans-Lathrop Insurance, Nowlan & Mouat Law Firm, Burdick Corporation, the governor's office, Beloit School District, the Beloit *Daily News* and Warner Electric.❖

Obituaries

Bonner, Joseph N., MD, died Oct 14, 1993, in N Fort Myers, Fla. He was born Nov 4, 1915, and received his medical degree from Georgetown University. He served surgical residencies at Boston City Hospital, the New England Deaconnes, the Lahey Clinic and the Boston Faulkner Hospital. He served 4 years of active duty in the Army Medical Corps and returned to Boston to continue surgical training. He was in practice in Appleton for more than 36 years. Dr Bonner was a staff member of the Medical Arts Clinic (La Salle) for more than 31 years, serving as clinic president. He was a member of the Wisconsin Surgical Society, the Outagamie County Medical Society, and the SMS. Dr Bonner is survived by his wife, Rosemary; five daughters, Susan Bonner Kuhrts, of San Diego, Nancy Cecile Bonner, of Columbus, Ohio, Mary Jo Bonner Dernbach, of Naples, Fla, Beth Bonner Gall, MD, of Dubuque, Iowa, and Patricia K. Bonner, MD, of Washington, DC. He is also survived by three sons-in-law, George Kuhrts, Paul Dernbach, MD, and Warren Gall, MD, as well as nine grandchildren.

Caffrey, James F., MD, died Dec 30, 1993. He was born Jan 23, 1923, in Scranton, Penn, and graduated from Marquette Medical School. He was a veteran of the US Navy. Dr Caffrey was a co-founder of Psychiatric Services and was one of the first psychiatrists in the area. He had a private practice in Green Bay for 33 years, and served as chair of the Department of Psychiatry at St Vincent Hospital. He also performed duties at the Brown County Mental Health Center. Survivors include his wife, Janet; six daughters, Beth Caffrey, of Washington state, Bridget Caffrey, of Minneapolis, Clare Caffrey, of St Paul, Susan Caffrey, of Minneapolis, Margaret Caffrey, of Chicago, and Moly Caffrey, of Los Angeles; three sons, John of Chicago, Tom of Milwaukee, and Dan of Minneapolis; six grandchildren; one sister and one brother.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

Cohen, Philip P., MD, formerly of Madison, died Oct 25, 1993, in Portland, Ore. He was born Sept 26, 1908, in Derry, NH. Dr Cohen received his medical degree from the University of Wisconsin-Madison. He completed a National Research Council Fellowship at the University of Sheffield, England, served as an instructor at Yale University, and joined the faculty of the University of Wisconsin Medical School in 1941. He was chair of the Department of Physiological Chemistry from 1948 through 1975, acting dean of the UW-Medical School from 1961 through 1963, and a member of the University Committee, serving as chair in 1970. Dr Cohen was named emeritus professor in 1979. Dr Cohen is survived by three sons, Dr Philip T. (Peter) Cohen, of San Francisco, David B. Cohen, of Fond du Lac, Dr Milton T. Cohen, of Portland; one daughter, Julie Anderson, of Portland; six grandchildren; one brother and one sister.

Dunst, Carl G., MD, died Oct 29, 1993, in Milwaukee. Dr Dunst was a graduate of the University of Louisville Medical School. He began practicing medicine in Milwaukee in 1933. He served in the Navy medical corps in the Pacific from 1943 to 1946. He returned to Milwaukee and was a staff physician at St Mary's Hospital for more than 50 years. He was also the track physician at State Fair Park. Dr Dunst is survived by his daughters, Anne De Leo, Wauwatosa, and Vera Becker, of King's Mountain, NC; three sons, Karl-Mario of Campbellsport, Jerome of Aberdeen, SD, and George of Madison; 10 grandchildren and nine great-grandchildren.

Fine, Jacob M., MD, died Oct 23, 1993. He graduated from the University of Toronto Medical School in 1926, and interned at Mt Sinai Hospital in Milwaukee. He joined Dr Jack Ackerman in his Cudahy practice at the end of 1928, and later co-founded the Fine-Lando Clinic with Dr David Lando. Dr Fine's specialty was cardiology. He was an Army captain, serving in the Aleutian Islands and England during World War II. He was a founder of Trinity Memorial Hospital and its first chief of staff. He retired from the Fine-Lando Clinic at the age of 75. He then joined the South Milwaukee Clinic, practicing until his final retirement at 84. He was a member of the Medical Society of Milwaukee

County and the SMS. Dr Fine is survived by a son, Louis; a brother, Dr Archie Fine, of Cincinnati; seven grandchildren and five great-grandchildren.

House, Jerome W., Jr., MD, died Nov 9, 1993. He graduated from Marquette Medical School in 1958, and served his internship at Milwaukee Lutheran Hospital and his residency at Columbia Hospital, specializing in orthopaedic surgery. Dr House was a member of the Medical Society of Milwaukee County, SMS, International College of Surgeons, and the American Academy of Orthopaedic Surgeons. He is survived by his wife, Janice; two sons, Thomas and Peter; stepsons, David, Jeffrey, Daniel, and Michael Luellwitz; and six grandchildren.

Huebner, Jewel Steiner, MD, died Oct 10, 1993, in Oshkosh. He was born July 22, 1912, in Forest Junction. He graduated from the University of Wisconsin-Madison Medical School in 1938. Dr Huebner was in general practice at the former Wiley-Smith Clinic in Fond du Lac from 1941 until his retirement in 1973. He was an EAA medical examiner and was the medical director for the EAA convention. Dr Huebner is survived by his wife, Ramona; a brother, Merlin, of Appleton; and a nephew.

Johnson, Ronald C., MD, a retired West Allis pediatrician, died in Boca Raton, Fla. He graduated from Marquette University School of Medicine in 1956. He served an internship at St Luke's Hospital and residency at Milwaukee Children's Hospital. Dr Johnson was a pediatrician in West Allis for more than 30 years. He served on the staffs at Milwaukee Children's, St Luke's, and West Allis hospitals. He was an associate professor at the Medical College of Wisconsin. Dr Johnson is survived by his wife, Olive; a son, Joseph Johnson, of Boca Raton; two daughters, Kathryn Naylor, of Shorewood, and Carolyn Switalski, of West Allis; and one sister.

Kustermann, Alois F., MD, died Oct 31, 1993. Dr Kustermann, a native of St Nazianz, was a 1927 graduate of the Marquette University School of Medicine and began his practice under the guidance of his uncle, Louis Jermain, the first dean ofthe Marquette Medical School. Dr Kustermann was on the medical staff of St Michael and St Joseph's Hospitals and a clinical faculty member of the family medicine program at Marquette. In 1978, the Medical College of Wisconsin honored him for 50 years of service as a general practitioner. He is survived by four daughters, Mary Esser, of Wauwatosa, Susan Kampine, of

Continued on next page

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Continued from preceding page
Brookfield, Margaret Kustermann, of Chicago, and Helen Geismann of Wilmette, Ill; and three sons, John, of Hawaii, Paul, of Brookfield, and Thomas, of St Charles, Ill.

Logemann, Ronald L., MD, died Nov 3, 1993, in Shawano. Dr Logemann was born June 29, 1936, in Minnesota. He graduated from the University of Minnesota Medical School in 1962 and served an internship in Orange County, Calif. He practiced medicine in Shawano for 30 years, serving as medical director of the Shawano Clinic. Dr Logemann was a member of the American Academy of Family Practitioners, Physicians for Social Responsibility, the AOA, the Shawano County Medical Society, and the SMS. Dr Logemann is survivedby his wife, Kay; four sons, Tim, of Wausau, Tony, of La Crosse, Andy, of La Crosse, and Nick, of Eau Claire; four daughters-in-law, five grandchildren, his father, Fred Logemann, and a sister.

Milliken, Lyle David, MD, formerly of Kenosha, died Oct 7, 1993, in Santa Barbara, Calif. He was born July 10, 1923, in Ord, Neb, and received his medical degree from the University of Nebraska College of Medicine in Omaha. He trained in the US Navy College Program from 1943 to 1945, and served as a medical officer aboard personnel transports in the North Pacific from 1949 until 1951. He was awarded the Battle Star for service during the Korean War. Dr Milliken interned in general surgery at St Luke's Hospital in Cleveland, and Grody Memorial Hospital in Atlanta. He was a general surgery resident at Henry Ford Hospital in Detroit. His urology residency was at the Medical College of Wisconsin in Milwaukee. Dr Milliken was a general surgeon and urologist in Kenosha from 1955 to 1989. He was a member of the Kenosha County Medical Society, AMA, SMS, Wisconsin Surgical Society, and Wisconsin Urological Society. He is survived by his wife, Ruth Ann; a son, David Daniel, of Kenosha; and two daughters, Jane Ann Milliken, of Denver, and Susan Amy Milliken, of Calabasas, Calif.

Struthers, James L., MD, died Nov 11, 1993. He was born on Oct 24, 1922, in Monmouth, Ill, and received his medical degree from the University of Illinois in 1950. He served an internship at Milwaukee County General Hospital. Dr Struthers practiced general internal medicine in Wausau from 1956 to 1972, and at the Marshfield Clinic from 1972 until his retirement in 1984. He was a member of the Society of Internal Medicine, the College of Physicians, the SMS, and the Wood County Medical Society. Dr Struthers is survived by four sons, Alan, of Lac du Flambeau, Mark, of Madison, James, of Milwaukee, and David, of Lacey, Wash; one brother; and one grandson. His dear wife, Betty Lou, died with him in a tragic car accident.

Zintek, Arthur R., MD, PhD, died Dec 11, 1993. He was born March 4, 1911, in Milwaukee. He graduated from Marquette University Medical School, engaged in private practice in Durand and joined the Wisconsin State Board of Health in 1940. He received his public health doctorate from the University of Michigan in 1946, and was instrumental in the discovery of the polio vaccine. Dr Zintek was a member of the Washington County Medical Society and the SMS. He is survived by his wife, Themla Lucia; daughters Margaret Smithson, of Cazenovia, Cathy Johnston, of Wauwatosa, Betty Azpell, of Elm Grove, Carol Cinclair, of Plano, Texas, Mary Ellen Wenninger, of Barrington Heights, Ill, Annie Wenninger, of Hartford; a son, Arthur, of Elm Grove; 22 grand children, 12 great-grandchildren; and two sisters.◆

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All manuscripts will be edited by the *Journal* staff for clarity, organization, grammar, spelling, and punctuation, and in accordance with AMA style (AMA *Manual of Style*, 8th ed, and AMA *Manual for Authors and Editors*). Suggestions for titles are welcome, but are subject to the constraints of clarity, space, grammar and style.

The corresponding author will be asked to review a galley proof prior to publication to verify statements of fact. Galley proofs are for correcting errors; revisions should be made before submission, but must be made prior to final acceptance of the paper. The authors are responsible for all statements made in their work, including any changes made by the editors and authorized by the corresponding author.

Preparation of scientific manuscripts

- Submit papers to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701; Ph: 608-257-6781 or 1-800-362-9080; FAX: 608-283-5401.
- Authors are encouraged, whenever possible, to submit manuscripts on computer disks, using IBM-compatible software. Electronic submissions are also possible. A printed copy must accompany all disk and electronic submissions.
- Typed manuscripts must be submitted in triplicate (one original, two photocopies). Type on one side only of standard-sized white bond paper, using 1-inch margins. Double-space throughout.
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References--Limit to 20. Authors are responsible for the accuracy and completeness of references. References must follow AMA style and abbreviations of journal names must follow those in *Index Medicus*. Consult the *Wisconsin Medical Journal* for examples of proper form.

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- Do not use abbreviations in the title or abstract, and limit their use in the text. Acceptable abbreviations of clinical, technical and general terms can be found in the AMA *Manual for Authors and Editors* and AMA *Manual of Style*.
- Avoid the use of medical jargon. Words or phrases that are particular to conversations among medical personnel are inappropriate in scientific writing. (Examples: For "presented with" use "had;" for "experienced a weight loss" use "lost weight.")
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- Provide each author's full name and highest academic degree in the

byline. If an author holds two doctoral degrees (eg, MD and PhD, or MD and DDS), either or both may be used, according to the author's preference. Honorary American designations (eg FACP or FACS) are omitted. If the author holds a doctorate, master's and bachelor's degrees are omitted. Courtesy titles (eg, Mr, Mrs, Ms) are omitted from bylines and text.

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BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

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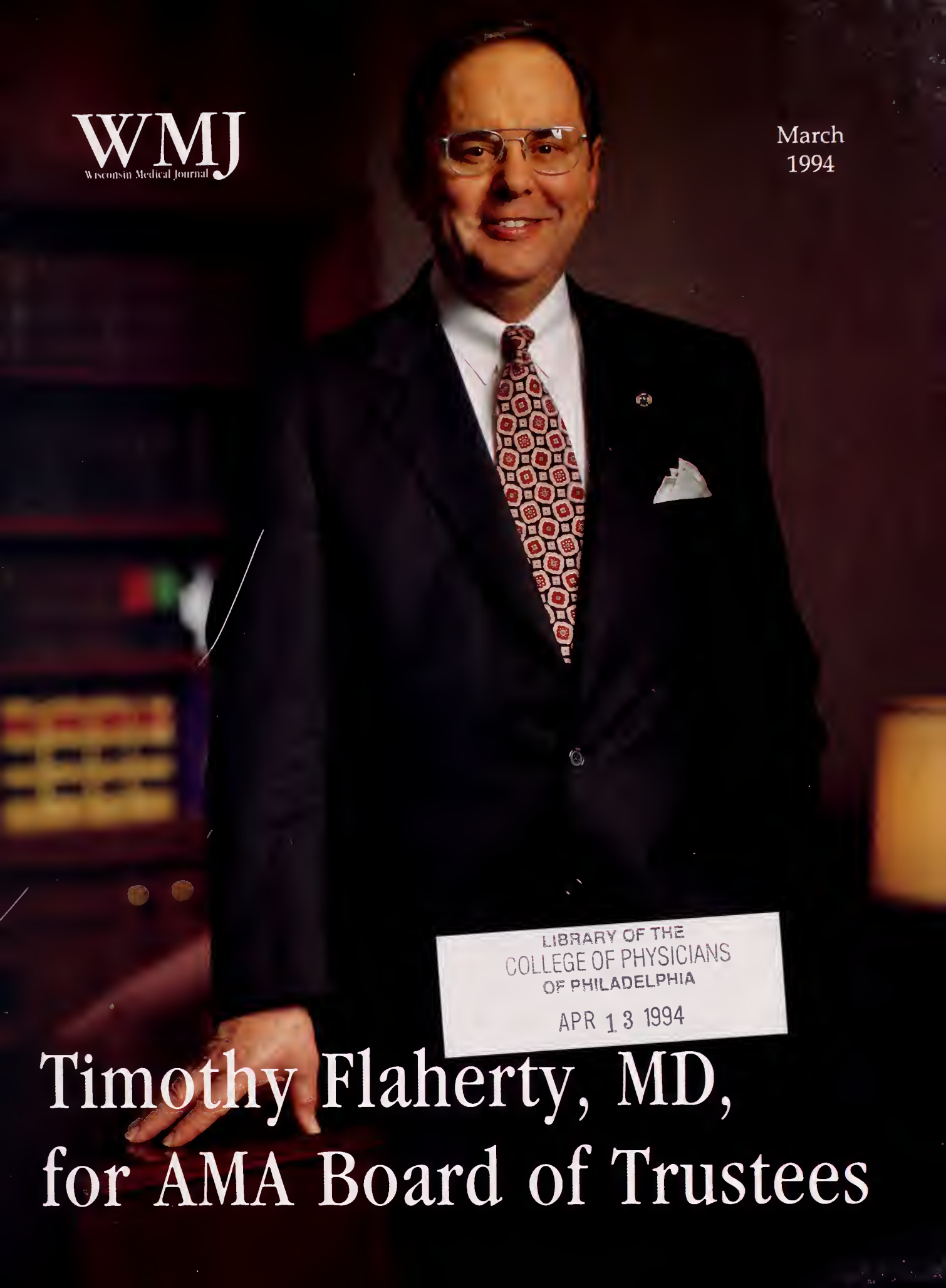

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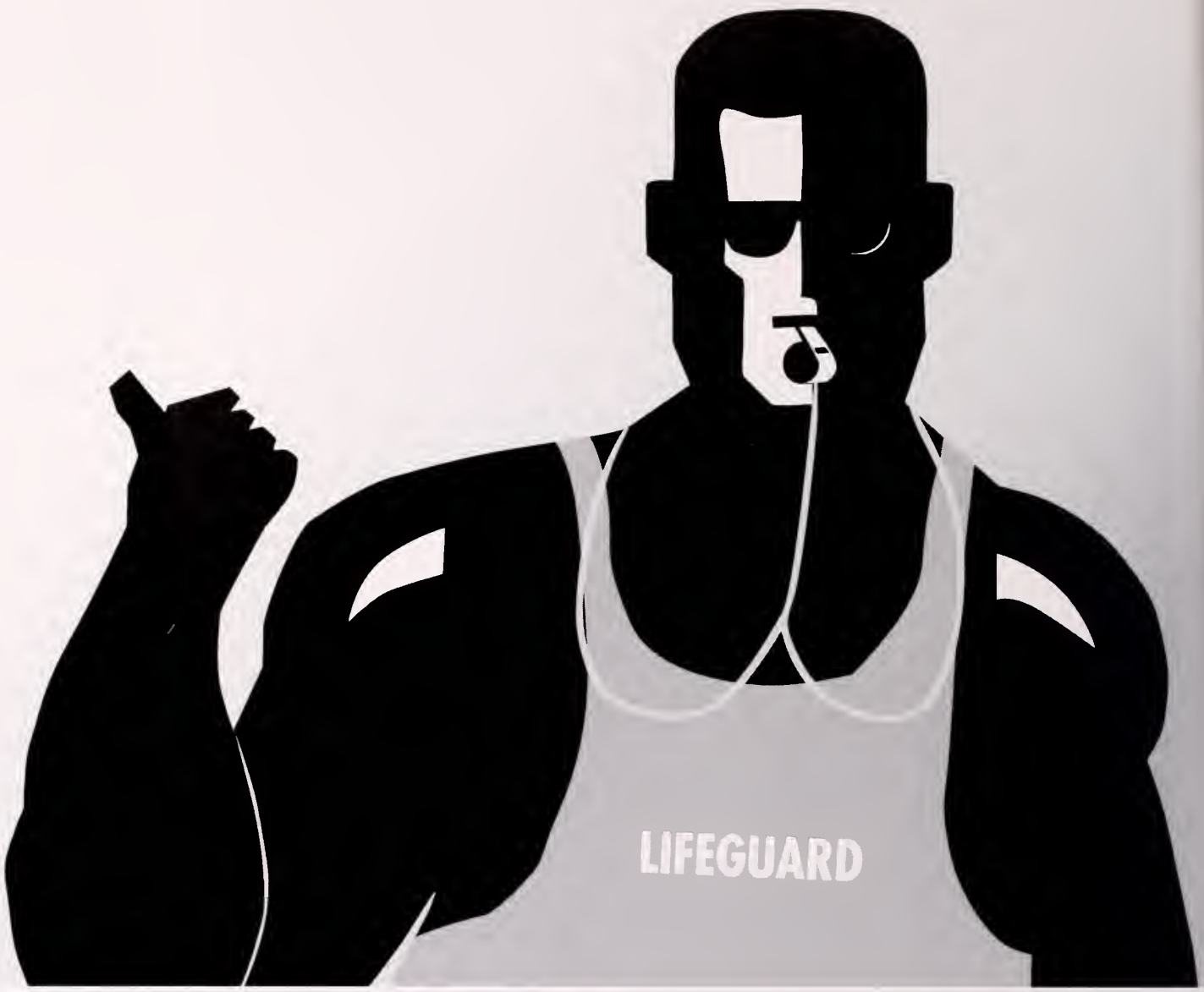

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Contents

March 1994 Vol. 93 No. 3

Opinions

99 *President's page*
We have very good friends at 330 Lakeside
by Pauline M. Jackson, MD, La Crosse

101 *EVP report: The view from here*
Taking measure of the new AMA
by Thomas L. Adams, CAE, Madison

102 *Letters*
Health care, rights and the Wizard of Oz
by Howard Correll, MD, Arena

103 *WMJ* article on carpal tunnel release inspires discussion
by John J. Siegert, MD, MS, FACS, Whitefish Bay

Scientific

107 Experience with macroscopic vasectomy reversal at the Medical College of Wisconsin
by Douglas M. Dewire, MD, and Russell K. Lawson, MD, Milwaukee

109 The surgeon, needle-sticks, and HIV
by Donald H. Kranendonk, MD, Wausau

113 Proceedings of the 1993 Wisconsin Primary Care Research Forum

Socioeconomic

125 *Public health*
Preventable causes of death in Wisconsin
by Patrick L. Remington, MD, MPH, Madison

Organizational

129 AMA candidate Tim Flaherty, MD, tackles issues facing physicians
by Shari Hamilton, assistant editor

136 *Book review*
Out of Dr Bill's Black Bag: From Northern Wisconsin a Country Doctor Looks Back
by Russell King, editor

137 SMS Executive Committee calls for withdrawal of Blue Cross lawsuit

138 SMS commission updates guidelines on terminal care in long-term care facilities and at home

138 SMS Board restructures Commission on Safe Transportation

140 Physician briefs

142 County society news

143 WIPRO investigated

144 CES Foundation donors

145 Obituaries

Our cover: Timothy Flaherty, MD, for AMA Board of Trustees. See page 129.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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President's page

We have very good friends at 330 Lakeside

As I WRITE THIS, my year as president is winding down or, more accurately, crescendo-ing to a fast stop on April 14 when I hand off the baton to Dr Roberts. Each SMS president's role necessarily varies with the immediate needs of the Society, daily politics, and our unique (to use a generous term) personalities. Some presidents may be remembered as shining meteors, others as steady supports, but whatever one-year differences we bring to the SMS, the work of the Society goes splendidly along, with only a week of staff exhaustion after the annual meeting to make a blip on the screen.

SMS members who have had the opportunity to work with our staff know firsthand what I'm talking about. Others get a good idea from reading *Medigram* and the *Journal*, from attending county and state society meetings, and from individual contacts such as a single telephone call requesting advice.

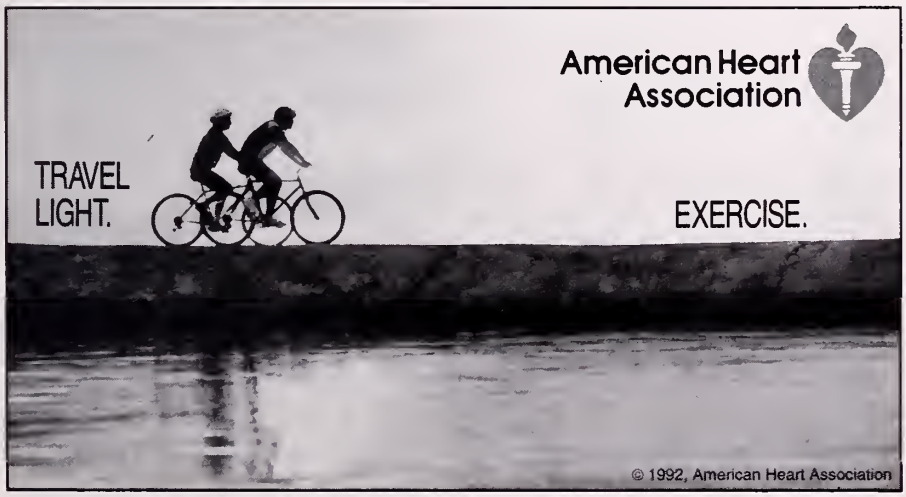
Our SMS staff has no parallel of which I know and is highly respected among medical organizations nationally. We aren't just lucky to have these people. Our dues pay their keep, and I can tell you it's worth every dollar.

I have had many experiences in the past year, but none is so memorable as my comfortable relationship with SMS employees. I want every member of the Society to know how important these people are to our success and survival as Wisconsin physicians. You might mention this to your few colleagues who are not SMS members. A lot of what these individuals do is for them also.

Pauline M. Jackson, MD

From the telephone operator to the EVP, from the cleaning staff to the ghostwriters (and yes, like all busy presidents, some of our output is ghosted), from the field staff (who rarely sleep) to the executive secretaries (all the secretaries are executives--just ask those for whom they labor), and on and on through the canyons and corridors at 330 East Lakeside, these are exceptional people who care about what they do. They listen, they formulate, they advise when asked to do so, but they do not impose. They are classy.

I want to take this opportunity to give them a big vote of appreciation from you and from me.❖



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EVP report: the view from here
Taking measure of the new AMA

THE COVER STORY for this edition of the *WMJ* features Neenah physician Timothy Flaherty, MD, who has been nominated for a seat on the AMA Board of Trustees. This seems like an appropriate time to reflect on the current evolution of our national organization.

Perhaps Dr Flaherty himself provides an accurate measure of the AMA's health and vitality. In my 18 years of service to medical associations, I have rarely seen a Board of Trustees candidate as uniquely qualified as Dr Flaherty. Those of you who have kept abreast of the AMA over the past couple of decades know that this is no small tribute: past president of the SMS, vice chair of the AMPAC Board of Trustees, corporate director, and--above all--an outstanding citizen, he personifies the best of the medical profession. If elected, he will bring a strong voice to the effort to preserve medical practice for those who will face the myriad challenges of medicine's future.

That the AMA would attract men and women of Dr Flaherty's caliber speaks volumes about the increasing caliber of the AMA. From the grassroots membership to the Board of Trustees, to Dr Jim Todd and his outstanding staff, the AMA is a creature of renewed vigor and commitment.

Rising to the challenge of health system reform has been a revitalizing factor for the association. That challenge has been well met, given the number and strength of the forces arrayed in the debate. The essence of this latest stage of AMA evolution, however, lies closer to home.

It is you. The source of the AMA's renewed strength is found primarily in the renewed involvement of physicians from Hurley to Houston and the enhanced activities of every part of the federation of organized medicine.

It's all of us together. And, yes, the AMA represents all of us, regardless of whether we actually pay our membership dues. Member or not, you're represented in the AMA by both your SMS delegation and the delegation for your specialty society. Member or not, when the AMA speaks the nation hears it as your voice. Member or not, you have reaped the benefits of the AMA's extraordinary work in these extraordinary times.

Actually, for a medical society of only 8,000 members, Wisconsin physicians have remarkable representation and an impressive record of leadership within the national organization. Currently, Dr Ken Viste is vice chair of the AMA Council on Legislation, Dr Kim Scott is member and former chair of the AMA Council on Long Range Planning and Development, Dr Kermit Newcomer is vice chair of the AMA Council on Medical Service, and Dr Flaherty, now running for the Board of Trustees, is secretary of the AMPAC Board of Directors.

So Wisconsin--historically the "little" state that produces the big ideas--has had more than a little to do with the revival of the AMA. Perhaps more importantly, Wisconsin will have the opportunity to help shape the future of the AMA and of the profession. You will no doubt be forgiven if you indulge in a moment or two of pride.❖

Thomas L. Adams, CAE

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board. Write to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.❖

Letters

Health care, rights and the Wizard of Oz

To the editor: The World Health Organization, in the early 1940s, defined itself as guardian of the physical, emotional, and mental well being of all people. It failed through inability to understand the competition between emotion and reason in the mind of man.

This is being repeated in the proposal for unlimited, non-repealable health care insurance for every American, discussed by legislators and consumer groups. They do not see this as the Wizard of Oz: Henry Morgan replaced by a wizard and wizardess; its site moved from Kansas to Arkansas, and Oz to Washington; the wicked witches played by a Congress "person" from the west, suing his electorate for, by law, preventing his "right" to re-election, and a senator from the east, supporting everything his president proposes.

But what are "health care" and "rights"? Health care was a term politicians devised about 50 years ago as a synonym for medical and hospital care, while rights are privileges governments may (not must) grant its constituents.

First, can there be a right to health care if there is no possible cure? The first medical cure for any disease since man trod the earth occurred in the mid 1930s. It was a political non-issue until cure made it one.

Second, the first curative drug developed was a German aniline dye substitute for vegetable dyes, not as a medical cure. I first saw its medical use in 1938, while a third-year medical resident.

It was a medical cure miracle, which raised a third question: Why is it a right confined to Americans, not Germans, or to everyone, since its use, and the lives saved, caused both destructive overpopulation and exhaustion of the planets finite resources?

Fourth, why should the wizard and mate, who first dampened a diaper some 10 to 15 year later, be the prescient discoverers of this "right" denied only their electorate?

Fifth, why, instead of extending health care as defined by the WHO, do they grant only "medical and hospital care insurance," paying no attention to its precursors of slum eradication; jobs; family cohesion; clean, friendly neighborhoods; two-parent families; religious indoctrination; and personal and community pride?

Without these precursors to medical care, can there be improved health? Instead will it not result in waste of resources destroying all multicellular life in a tragedy as great as the extinction of the dinosaur? Not first resolving these questions negates use of the sophisticated and expensive emergency room care now legislatively mandated of hospitals to replace personal medical care in those people politicians claim have no medical care.

Darwin speculated for years on the origin of the species, then concluding the trial and error of evolution was a logical answer, not replacing, but explaining the belief of a creator, called evolution or God. What was not appreciated, were the relationships in his postulates, such as life emerging from a single cell living in sea water nurturing it, slowly increasing into cell clusters, then differentiating into functional groups as organs, forming the complex multicellular, sea and land living organisms of today.

This course is documented in the dictum that phylogeny (racial history), repeats ontogeny (the life cycle of organisms), demonstrated in embryology, (the microscopic study of developing multicellular life). Darwin thought that such complex systems of cells needed a communication network termed the central nervous system, integrating the functions of this creation for species protection. It required a center termed "emotion" in the mid-brain.

But species protection often was misused as personal protection with conflicting aims, requiring another center termed "reason" in the forebrain, less powerful but more selective, ameliorating without destroying the first.

Not recognizing these competing functions of "emotion," such as love, hate, anger, lust, prejudice and greed, and "reason" or thought in its effort to curb them, are the source of world conflicts and constitute the real problems for survival of life.

At issue is seeing the difference between responsibility to others, expressed as reason controlling greed, and the fallacy in "the right to health care for all Americans" not correcting the deteriorating education system and slums, the breeding ground of the problem. Rather, it adds to greed by acceptance of a "made in the USA right to medical and hospital care insurance," the failure for a politically perceived medical problem, substituting greed for reason.

—Howard Correll, MD
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WMJ article on carpal tunnel release inspires discussion

To the editor: As a fellowship-trained orthopaedic hand surgeon I read with interest the recent article in the *WMJ* titled, "A comparison of endoscopic and open carpal tunnel release" (*Wis Med J*.1993;92(12):675-677). Because your journal is read by a wide variety of physicians, many of whom are not familiar with the endoscopic technique of carpal tunnel release, I believe that several comments about the article are warranted so as to avoid inappropriate impressions by your readers.

First, it should be emphasized again that the study by Dr McDonough and Dr Gruenloh was a retrospective study comparing open carpal tunnel cases with endoscopic cases. There is no mention in the report of any randomization of patients, etc. Therefore, concerns arise as to how the patients were selected for the two different treatment options. Most experienced surgeons who deal with carpal tunnel syndrome extensively often will be able to predict in many cases which patients will tend to take longer to recover than others, even before the surgical procedure is undertaken. Therefore, in addition to the inherent limitations of a retrospective study, significant unintended biases can be introduced in a study that is not a prospective randomized study.

The second, and more important concern I have regarding this study, is that of the reported complications. It is noted that in each treatment group (open release v endoscopic release) one patient had recurrence of symptoms postoperatively though only in the endoscopic group did the patient require re-operation. It should be noted that aside from the one case of reported recurrent symptoms following open surgical release (subsequently treated non-operatively) surgical release group, ie, there were no nerve lacerations, no tendon lacerations, etc.

In contrast, in the endoscopic release group there was reported to be a patient with persistent paresthesias along the radial border of the ring finger and ulnar border of the middle finger at 20 months follow-up. This clearly represents injury to the third common digital nerve (a

Continued on next page

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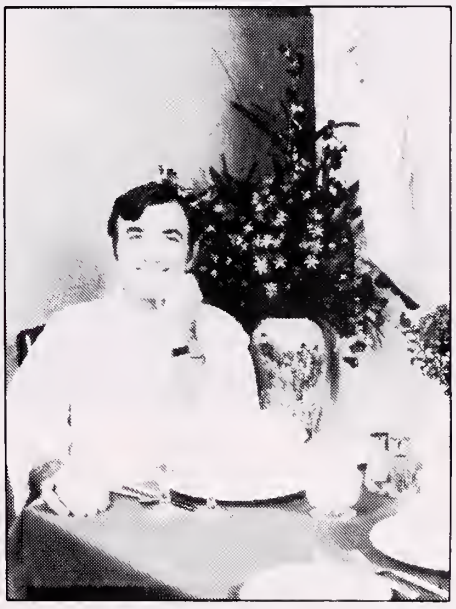

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branch of the median nerve). Since there has been no improvement at 20 months follow-up, this nerve dysfunction may represent a partial laceration to the nerve. (Common digital nerve lacerations are well known potential complications of endoscopic carpal tunnel release.) Also, there is the previously mentioned patient who required reoperation 18 months following the initial endoscopic release. And finally, though not mentioned in the results, but rather in the discussion section, there is the brief description of a patient who sustained a laceration of one of the flexor tendons to the little finger during endoscopic carpal tunnel release. Therefore, in total there were three significant complications from the endoscopic technique. In my experience such a rate is extremely high and would not be typical for the complication rate in open carpal tunnel release surgery.

These complications should be kept in mind when surgeons contemplate pursuing the endoscopic technique. There are even other more significant complications associated with endoscopic carpal tunnel surgery which have been reported in significant numbers around the country. In my opinion, and the opinion of many other hand surgeons, the reported decreased time lost from work with the endoscopic technique does not justify its utilization in most patients. In contrast to other endoscopic procedures (ie, abdominal operations), endoscopic procedures in the carpal tunnel provide less visualization of the pertinent anatomy than that of an open procedure. This is important in carpal tunnel release surgery since in a number of individuals open visualization is the only factor which allows the surgeon to determine whether or not concomitant procedures (ie, flexor tenosynovectomy) should be pursued at the time of surgery so as to minimize the chance for recurrence of the carpal tunnel syndrome in the future.

Therefore, in my opinion, the conclusion in the article by McDonough and Gruenloh that the endoscopic technique for release of the transverse carpal ligament is "a safe and effective treatment for carpal tunnel syndrome" is not justified by the data presented. Rather, the data presented suggest just the opposite conclusion. In light of the broad readership of the *WMJ* I believe that the conclusions in the article may mislead physicians who treat carpal tunnel syndrome on an occasional basis into recommending or performing surgery which has greater risk and potential complications.

Finally, it should be appreciated that in the hand surgery literature there are numerous recent articles concerning endoscopic carpal tunnel release, both for and against this procedure. Unfortunately, many of the largest studies to date have been carried out by individuals who have direct financial ties to the equipment used in this technique. Therefore, even studies with large numbers must be interpreted with caution. Perhaps the most honest and telling story of this new technique was a recent informal poll of a large number of hand surgeons at the 1992 annual meeting of the American Society for Surgery of the Hand. Although approximately half of the surgeons in attendance were performing this endoscopic technique on their patients, when asked whether or not they would have endoscopic v open release if they themselves had carpal tunnel syndrome, approximately 90% of the

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surgeons in attendance (including myself) stated that they would have the release done in the standard open fashion and not endoscopically.
--John J. Siegert, MD, MS, FACS
Whitefish Bay❖

The author responds

We appreciate the opportunity to respond to the thoughtful comments of Dr Siegert.

Patients were not selected for the endoscopic or open treatment groups because we could predict that a particular patient would have a long or short recovery. We endeavored to eliminate selection bias by studying, all of the 107 carpal tunnel release procedures we performed between September 1990 and March 1992.

The first 50 consecutive carpal tunnel release procedures of these 107 cases were performed open, and the next 57 consecutive carpal tunnel procedures were performed endoscopically. Seven of the endoscopic group were excluded because they were converted to open procedures due to poor visualization of the transverse carpal ligament. The 57 endoscopic procedures represent the first 57 endoscopic carpal tunnel release procedures performed by the author (JWM). The author has 20 years of experience performing open carpal tunnel release.

Our paper addresses three complications in the endoscopic group, a 6% complication rate. This compares favorably with the published rate of complications (5% to 15%) using the open technique of carpal tunnel release.[1-3] This 6% complication rate occurred during the steepest phase of our learning curve for the endoscopic technique.

Since March 1992, we have performed approximately 150 additional endoscopic carpal tunnel release operations without known incomplete release, nerve, tendon or vessel complication.

We agree with Malek who recently analyzed the complications of 10,624 cases of endoscopic carpal tunnel release performed by 265 surgeons. Malek concluded that the endoscopic complication rate is comparable to open conventional carpal tunnel release.[4]

We believe that our data and the data presented by others support the conclusion that the endoscopic technique for release of the transverse carpal ligament is a safe and effective treatment for carpal tunnel syndrome and that the post-operative morbidity and time lost from work is decreased by the endoscopic method.[5-8]

The concerns raised by Dr Siegert are important and very real. This new endoscopic technique for the management of a common entrapment neuropathy is controversial and associated with a significant learning curve. It is not for every surgeon and not for every patient.
--John W. McDonough, DO
Wisconsin Rapids

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Continued from preceding page

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Editor's note

It is obvious from his letter that Dr Siegert does not embrace endoscopic technique for release of carpal tunnel.

He is quite right in that the study was not randomized and was retrospective, and I agree entirely that scientific validity is more certain in a prospective, randomized trial. I was astounded, therefore, by Dr Siegert's presentation of such anecdotal evidence as a show of hands at some meeting as a reason to abandon the endoscopic approach. I would remind him that the show of hands did not yield a unanimous vote. I would also remind him that the American Society for Hand Surgery, for all its strengths, is not omniscient regarding surgery of the hand.

I would also caution Dr Siegert to avoid statements such as "unfortunately many of the largest studies to date have been carried out by individuals who have direct financial ties to equipment used in this technique," for he may one day be asked to prove it.

Dr Siegert is also highly critical of the complication rate following endoscopic procedure: "In my experience such a rate is extremely high and would not be typical for the complication rate of open carpal tunnel release surgery." It would be much more illuminating for him to publish his series. Without this information, his criticism becomes similar to a tinkling bell in the ether of the universe.

--Richard Sautter, MD
medical editor❖

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Experience with macroscopic vasectomy reversal at the Medical College of Wisconsin

Douglas M. Dewire, MD, and Russell K. Lawson, MD, Milwaukee

Thirty-two men underwent vasectomy reversal using loupe magnification at the Medical College of Wisconsin between 1984 and 1991. Semen analysis and pregnancy data were available for 27 of them, and sperm were present in the ejaculate of 24, representing a patency rate of 89%. Pregnancy was established by 11, for a pregnancy rate of 41%. These results suggest that vasovasostomy using loupe magnification provides acceptable rates of patency and pregnancy, although the pregnancy rate appears to be somewhat lower than that reported for microsurgical repair. The lower cost of macroscopic vasectomy reversal may outweigh the potential statistical advantages for some couples. *Wis Med J.*1994;93(3):107-109.

VASECTOMY REVERSAL has become increasingly common in urologic practice over the past two decades. Several techniques of vasovasostomy have been described. These are best categorized as either macroscopic or microscopic. The results from series using these quite different approaches are surprisingly similar.[1-3] Thus, the debate surrounding macroscopic and microscopic repairs continues.

Those experienced with microsurgical vasectomy reversal have emphasized the need for frequent use of these skills to maintain one's surgical expertise in this area. Since microsurgical skills are vastly different from those employed in the usual scope of the urologic practice, the technically simpler macroscopic vasovasostomy has maintained its position in the stock of surgical skills of many urologists.

The current retrospective study was undertaken in an attempt to determine the expected results for the urologist performing vasovasostomy infrequently (once every 3 or 4 months) as compared to the infertility specialist performing the procedure weekly.

From the department of urology at the Medical College of Wisconsin, Milwaukee. Reprint requests to: Douglas M. Dewire, MD, Medical College of Wisconsin, Froedtert Memorial Lutheran Hospital, 9200 W Wisconsin Ave, Milwaukee, WI 53226. Copyright 1994 by the State Medical Society of Wisconsin.

Methods

Thirty-two men underwent vasectomy reversal using 2.0x to 4.0x loupe magnification at the Medical College of Wisconsin between 1984 and 1991. The mean patient age was 36 years (range 28 to 49 years). The mean interval from vasectomy to reversal was 6.4 years (range 1 to 18 years).

All procedures were performed on an outpatient basis, using local anesthesia with intravenous sedation. Anastomoses were completed without stents using a modification of the technique described by Middleton.[4] Briefly, two 8-0 nylon sutures were placed from the lumen through the entire thickness of the vas 180° apart. These were followed by four to six interrupted 7-0 or 8-0 nylon sutures approximating the outer muscular portion of the vas deferens.

Patients were allowed to resume their normal activity after 3 to 5 days, depending on their level of comfort. They were asked to abstain from sexual intercourse for 3 weeks. A semen analysis was obtained 1 to 3 months post-operatively.

The medical record of each patient was reviewed to determine data for semen quality. Patients were contacted by telephone to determine pregnancy status as of July 1993.

Results

Outcome assessment including semen analysis and pregnancy data were available for 27 of the 32 men (84%) who underwent vasectomy reversal at our institution between

1984 and 1991. Sperm were present in the ejaculate of 24 men, representing a patency rate of 89%. Eleven men (41%) established pregnancies during the study interval.

A complete semen analysis including sperm count, percent motility, and morphology was performed by our laboratory in 23 patients. Semen quality was determined according to World Health Organization standards for normal.[5] Specifically, these criteria include: a count of at least 20 million sperm/mL, progressive motility of at least 50%, and 30% or more morphologically normal forms. Five men (22%) had normal postoperative semen quality in all three parameters. Fifteen (65%) men were subfertile in one or more parameters. Three patients (13%) had no sperm present in the ejaculate.

When pregnancy outcome was stratified according to semen quality, 60% (3 of 5) of the men with normal post-operative semen analyses established a pregnancy, while 40% (6 of 15) of the patients with subfertile semen quality produced pregnancies. This data is summarized in the accompanying table.

Relationship between post-operative semen quality and pregnancy outcome for men undergoing loupe vasovasostomy at the Medical College of Wisconsin (N=23).

Semen quality*	No. of men(%)	Pregnancy rate (%)
Fertile	5 (22)	3/5 (60)
Subfertile	15 (65)	6/15 (40)
No sperm present	3 (13)	0/3 (0)

* As determined by WHO guidelines for count, motility, and morphology.

Discussion

Approximately 1 million men undergo vasectomy in the United States each year.[6] Lee has estimated that 1 of every 500 men undergoing vasectomy will at some point in their lives desire reversal.[2] With ever-rising rates of divorce and remarriage, the number of men requesting vasectomy reversal will undoubtedly rise as well.

A strength of the current study is the excellent follow-up, with outcome data available for 84% of patients. A primary criticism of previously reported series of vasectomy reversal has centered around patient follow-up, with 17% to 59% of patients failing to return post-operatively.[3,4] This problem has been attributed to the relatively mobile population presenting for vasectomy reversal.

In the evolution of vasectomy reversal, two divergent surgical strategies have emerged: namely, macroscopic repair, and microsurgical repair. A potential advantage of macroscopic repair is lower cost to both the patient and the surgeon. Specifically, macroscopic repair can be done safely on an outpatient basis using local anesthesia, thereby avoiding anesthesia-related charges. Performing the procedure in a surgical center or clinic could further reduce the direct cost to the patient. Because operating microscopes range in cost from $50,000 to more than $100,000, the potential savings to the surgeon and the hospital offering macroscopic vasectomy reversal are significant as well.

The primary advantage of microsurgical vasectomy reversal has been superior results. Fenster[1] and Lee[2] have compared their results for macroscopic and microscopic vasovasostomy. Patency rates range from 84% to 90% for macroscopic repair, and from 90% to 96% with microsurgical repair. The Vasovasostomy Study Group reported an overall patency rate of 86% for microsurgical vasectomy reversal.[7] Our 89% patency rate supports the contention that sperm are likely to be found in the ejaculate after vasovasostomy, no matter what technique is used to accomplish the repair.

Pregnancy rates following macroscopic vasectomy reversal have ranged from 36% to 53%.[3,8] The overall pregnancy rate for microsurgical repair reported by the Vasovasostomy Study Group was 52%.[7] A direct statistical comparison between the reported series is impossible, but the published data do support the contention that microsurgical repair offers a slightly greater likelihood of pregnancy as compared to macroscopic repair.[1,2,7] Nevertheless, the potential cost advantages of macroscopic repair could outweigh the statistical advantages of microsurgical repair for some couples.

We believe that vasovasostomy using loupe magnification provides acceptable rates of patency and pregnancy as compared to microsurgical repair, although the pregnancy rate appears to be slightly better with microsurgery. Because of the potential cost benefits to both the patient and the surgeon, as well as the relative simplicity of the technique, macroscopic vasovasostomy will continue to play a role in the management of post-vasectomy male infertility.

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The surgeon, needle-sticks, and HIV

Donald H. Kranendonk, MD, Wausau

This review article looks at needle-stick injuries and human immunodeficiency virus (HIV) conversion from a surgical perspective. Is the risk high or low? That depends on: the rate of HIV in your patients (varies by region); the likelihood of getting injured (varies by specialty); and the HIV conversion rate from the injury (an elusive number that varies with the injury). The current literature was reviewed to see how risky surgery currently is. This leads us to speculate on the HIV risks of the near future. *Wis Med J*.1994;93(3):109-113.

THIS ARTICLE IS a literature review of surgical needle-stick problems. It is written from a surgeon's perspective and addresses HIV concerns and possible surgical technique and equipment changes.

The risk of sero-conversion from performing even a single operation on an infected patient is calculated to be 10 times the "accepted" annual occupational risk for a fatal injury.[1] "Becoming seropositive for HIV is the equivalent of death."[1] Working on a Louisiana oil rig is currently one of the most hazardous occupations for fatal injuries.[1] "The risk to the surgeons from performing 25 operations on infected patients is approximately 272 in 100,000.[1] The risk of fatal injury in the course of 1 year's work on a Louisiana oil rig is between 188 and 283 per 100,000."[1] Surgeons, therefore, are at equal or greater risk of death than oil workers on a Louisiana rig.

Surgeons have a very dangerous occupation,.[2,3] and by the standards applied to certain other public health concerns, the risks for HIV infection are high. For example, one provision of the Clean Air Bill proposed to shut down any industrial plant emitting a substance that caused a cancer risk higher than 1 in 10,000 to the most exposed individual.[1] If no worker in the chemical or nuclear industry is expected to endure a risk of cancer greater than 1 in 10,000, how can health care workers be required to assume a higher risk of HIV infection?[4]

There is no moral imperative to assume a risk that might be reduced by the employment of additional safety measures such as HIV testing. It is frequently stated that medical work has always been hazardous and that the risks are (or should be) freely accepted by all who choose this profession. In this sense, AIDS is considered to be the same as tuberculosis, plague, and other infectious diseases; but it is different in the sense that ordering diagnostic tests, labeling specimens, and placing isolation signs may be contraindicated for AIDS, while required for tuberculosis, varicella zoster, hepatitis, methicillin-resistant S.aureus infections, and other diseases.[1]

HIV should be treated like any other infectious disease. When caregivers are at risk because of an injury or an anticipated high risk procedure, patients should be tested regardless of whether they are suspected of having high-risk behavior. Workers can then protect themselves in the best possible way.[1]

If you get exposed to too much radiation, you just die. If you get

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Dr Kranendonk has developed a needle guard--the Kranendonk Point Guard--to be used for safety by surgeons. Neither the *WMJ* nor the SMS endorse, or make claims regarding the efficacy of, this product. For further information and reprints, contact: Donald H. Kranendonk, MD, 425 Pine Ridge Blvd, Wausau, WI 54401. Copyright 1994 by the State Medical Society of Wisconsin.

exposed to HIV, however, the public health effects are different. If one person infects one other person per year, and each of the infected contacts also transmits the disease to one person per year, the result would be 1,024 cases at the end of 10 years.[1]

In two studies, 63% and 65% of the HIV seropositive patients were unaware of their HIV infection before hospital admission.[5] Testing would identify the majority of these HIV patients and help them to obtain early treatment.[6] Recently, several AIDS experts have advocated routine testing of high-risk groups to allow early institution of therapy.[6] Hospital admissions certainly should have a higher return for HIV testing than the general public. The CDC recommends we offer HIV counseling and voluntary testing services to patients at risk.[5]

Most authorities have argued against routine testing of patients pre-operatively for HIV because it would not prevent or reduce the risks of infection to health care workers.[6] Most authorities argue that the risk from a single needle-stick is low, but surgeons are interested in their lifetime risk of infection.[6] Cumulative risk of HIV infection for the average surgeon now ranges from 1 in 5 to 1 in 100.[7]

Arguments against testing are that patients tested between the time they become infected and the development of antibodies might be missed.[6] There is also a question of enough time to test patients having emergency operations. Finally, while highly accurate, the results of enzyme-linked immunosorbent assay (ELISA) test for HIV might give a false negative or a false positive result.[9] False positives will cause serious anxiety until a repeat ELISA test or Western Blot test can be run to confirm or fail to confirm the initial positive test.[6] Patient confidentiality, counseling, false-positive results, and psychologic trauma are important problems. Greater efforts should be made toward solving them.[6]

Most HIV patients convert from exposure to seropositive between 3 months and 3.5 years.[8] A few do convert to seropositive very late. The disturbing fact is that the incubation period for this fatal virus can be up to 10 years before symptoms appear.[8,9] Testing would, however, identify the majority of HIV patients.[5]

The annual rate of medical interns becoming infected with the AIDS virus due to percutaneous puncture is 1 in 1,000.[10] By comparison, the risk of death for a California police officer is 1 in 4,000 and the annual risk of death for California fire fighters is estimated at 1 in 10,000. Thus, house officers' risk of acquiring HIV infection is in a range that certainly should concern occupational safety advisors and public policy makers.[1,10]

Surgeons are at a significantly higher risk.[10] The exposure rates for needle-stick accidents were broken down by specialty per year: On the average, general surgery residents and orthopedic residents are at 6 times higher risks than for internal medical residents.[10,11] The difference in risk over the span of a career, obviously, will be much higher. Obstetrics/gynecology also has very high needle injury rates.[11,12] Internal medicine is far from the lowest rate of exposure of specialties in medicine.[11]

In the past, confidentiality provisions of Wis Stat 146.025-5 applied only to health care providers, blood banks, and people who receive disclosures authorized by the statute. In 1992, this changed with the passage of Act 269. Now, no person, health care agent, or friend can disclose another individual's AIDS status regardless of how the individual acquired the information.[13,14]

In theory, you could be sharing needles or have a sex partner who has AIDS but no other friend, by law, has the right to even warn you of the risks.

It is far more likely the patient will bleed on his doctor than the reverse. An Alabama law on allowing HIV testing without informed consent was struck down as unconstitutional by a federal judge on Oct 7, 1993. Such testing, he said, would deny protection from unlawful search and seizure. We cannot test without special consent for the disease which will kill more than any plague in the history of man.[15]

Approximately 1 million people in the United States are HIV infected, according to the CDC. There are at least 2 million hepatitis B infected US residents.[16] In 1991, 29,850 US residents died from HIV infections, but this number is sky rocketing.[17] Surgeons usually do change their behavior in operating rooms when operating on patients seropositive for HIV.[1,6] Perhaps it is time to reconsider the policies of testing and management of AIDS. The problem of the unique stigma said to be associated with HIV disease should be addressed directly. Mandating ignorance may actually exacerbate that problem while ringing a harvest of deadly, preventable infections.[1]

Even if the AIDS management laws are corrected, surgeons must change. The increasing numbers of AIDS patients will increase our risks and necessitate procedural, device, and instrument changes.

Universal precautions as outlined by the CDC as far back as 1983 for isolation precautions in hospitals are in practice not followed, and if they could be followed are inadequate in 1993.[10,18] There need to be specific technical guidelines. Treating everyone as if they have AIDS is impossible.

We must stop needle-stick and sharps injuries, which account for more than 80% of occupationally acquired cases of HIV infections in health care workers.[18] Many such injuries may be preventable with changes in devices, techniques, or protective equipment.[19] Suture needles caused 77% of the injuries, 3% were caused by bovies, scalpels,

and wire. Other sources include suture thread cuts, bone fragments, bone hooks, orthopedic pins, cannulas, retractors, scissors, staple guns, and trocars.[19]

Needle-stick injuries are the most common injury to health care workers and represent the greatest risk of occupational exposure to AIDS and hepatitis.[20] Sixty-seven percent of sharps injuries in surgical personnel were caused by needles and usually occurred during suturing.[21] Eighty-four percent of reported occupationally acquired HIV infections were caused by percutaneous injuries.[20]

There are 800,000 occupational needle-stick injuries in the United States each year. Roughly 16,000 of these needles are likely to be contaminated by HIV.[20] As many as 60 health care workers may become infected with HIV annually as a result of occupational exposure.[20] This number is considered extremely inaccurate because of very low needle-stick reporting and the long incubation period for HIV.[11] Dr James Curran, head of HIV and AIDS for the CDC stated on the "60 Minutes" television program (Sept 24, 1989) that the number of on-the-job infections is inaccurate but probably "less than several hundred."[8]

The chance of contacting the AIDS virus from one needle-stick is the same as having anal sex or gay sex once.[8] In a recent Southern California study, medical students and residents actually reported only 9% of their needle-stick injuries.[11] Surgical residents had a six-fold greater rate of needle-sticks compared with medical residents.[11] In my experience, almost no one reports needle-sticks.

There are 50,000 to 75,000 HIV-infected health care workers in the United States, including 7,000 to 10,000 infected physicians.[22] Health care workers who sustain accidental needle-stick injuries face a real risk of acquiring HIV infection.[20] Percutaneous injuries were evaluated during 1,382 surgical procedures. Almost 7% resulted in percutaneous injury, and 77% of those were caused by suture needles.[19] Glove perforations occur in 10% to 50% of surgical procedures, and the majority of those are from the handling of a suture needle.[12] In 234 observed operations, cuts or needle-stick injuries occurred in 15%.[3] Of surveyed orthopedic surgeons, 39% had received a needle-stick or cut with a contaminated object in the month preceding the survey.[23]

Analysis of surgical glove perforations show nearly two thirds of the perforations were located on the fingers of the nondominant hand,

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suggesting perforation due to direct grasping of the needle.[12] The average cost of a needle-stick injury was $405.[24] The direct cost of follow-up after needle-stick injury ranges from $200 to $1,200.[20] Health care expenditures in the United States in 1991 were $666,000,000,000, of which medical and surgical supplies accounted for 1%.[25] If special supplies are available which improve safety, their costs generally are insignificant.[20]

Conclusions

We must change to stay alive. We must constantly look for solutions. These are some of the techniques and supplies that surgeons must use regularly: wearing two pairs of gloves; elbow or above elbow gloves; gloves for dressing changes, injections, and suture removal; waterproof high boots and aprons; improved waterproof gowns; face shields; hoods and "space suits"; blunt needles; special needle disposers; Kranendonk Point Guard; and restricted use of high speed saws, burs, and power equipment. We need Mayo tray transfers only, reduced passing of surgical instruments, slow motion movements, and no inexperienced staff.

Wearing two pairs of gloves is important. Single gloved hands revealed the presence of visible blood in 38% of cases, where as visible blood was noted on only 2% of the double gloved hands.[26] In 30% of the operations in an orthopedic trauma theater either the surgeon or the scrub nurse has a glove perforation.[2] Wearing two pairs of gloves induces clumsiness and in that way may increase sharp injury risks. The dipped gloves and the mesh gloves are very clumsy and are not designed to reduce needle-sticks.

At this time, most of the ideas listed above are in regular use or being evaluated. Even with all of these precautions, two thirds of the needle perforations are on the fingers of the nondominant hand.[12] This is due to grasping or feeling for the surgical needle.[12] Never touch a needle again.

This is why the Kranendonk Point Guard was developed. You don't have to touch a surgical needle again. The American Hospital Association recommended in 1993 that we "use devices that provide a fixed barrier between the hands and the needle after use."[20] Currently, there are 80 FDA-approved safe needle devices.[20] Almost all address hollow needle problems.

The problem of solid, surgical needle-stick injuries has been addressed in this paper. Until now, there was no product on the market that we can find, including company and patent searches, that allows the surgeon to manipulate, tie, and reload the surgical needle, yet satisfy the recommendations of providing a fixed barrier between the hands and the needle after use. The Point Guard addresses and solves the surgeon's needle-handling problems and satisfies the American Hospital Association's recommendations by enclosing the needle in a hard plastic case during tying. Hospitals must continue to make evaluation and adoption of safer needle devices and the safer technology a top priority.[20] The adoption of safer needle devices provides a benefit that cannot be measured by cost alone.[20]

To date, the use of universal precautions has resulted in a reduction of the frequency of some types of blood exposure but has not been proven to reduce the frequency of needle-stick exposures.[19] Needle-stick and other sharps injuries in health care workers remain a significant concern. New and safer products need to be designed for the future.[27]

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Proceedings of the 1993 Wisconsin Primary Care Research Forum

THE SEVENTH ANNUAL MEETING of the Wisconsin Research Network (WReN), the 1993 Wisconsin Primary Care Research Forum, was held Oct 22-23, 1993, in Wausau, Wis. WReN, a statewide network of more than 600 primary care professionals interested in practice-based research, is organized under the auspices of the Wisconsin Academy of Family Physicians (WAFP) Research Committee and is supported by the WAFP and the Wisconsin Institute of Family Medicine (WIFM). This 2-day conference is planned as a working meeting for the participants--it includes presentations by invited speakers, original research papers by primary health care professionals and workshops related to conducting research in the office setting. The following abstracts represent presentations on original research. (From the Wisconsin Research Network. Contact: John Beasley, MD, WReN Director, 777 S Mills St, Madison, WI 53715. Copyright 1994 by the State Medical Society of Wisconsin.)

Antibiotic choice and patient outcomes in community-acquired pneumonia

William J. Hueston, MD, and Maria A. Schiaffino, MD, Eau Claire

INCREASES IN THE incidence of atypical pneumonias have led some authorities to suggest that patients with community-acquired pneumonias be started on broad-spectrum antibiotics. The aim of this study was to compare clinical outcomes in patients admitted to the hospital with community-acquired pneumonias treated with broad or narrow spectrum antibiotics and determine what clinical criteria were used determining which antibiotic was selected for initial therapy.

Methods

A retrospective review of all patients admitted to a 100-bed rural hospital with community-acquired pneumonia between February 1992 and February 1993 was performed. Patients with immunosuppressive disorders or taking immunosuppressive drugs were excluded from study.

Results

Patients who were started on broad spectrum antibiotics were on the average older than those started on

narrow spectrum agents. Broad spectrum antibiotics were almost more likely to be used by internists as compared to family physicians. No differences in length of hospitalization, mortality, or re-admission rates were found between patients started on narrow as opposed to broad spectrum antibiotics.

Conclusions

Despite warnings of increasing atypical community-acquired pneumonias, patient outcomes were no different for patients started on narrow or broad spectrum antibiotics. Since pneumonia is a common illness that often prompts admission to the hospital, these findings may have important economic implications.

Send inquiries to: William J. Hueston, MD, Eau Claire Family Practice Residency, 807 S Farwell, Eau Claire, WI 54701.

Community health assessment in Mauston, Wisconsin

Alison L. Craig; James Logan, MD; and Barbara Hug, Mauston

COMMUNITY-ORIENTED primary care (COPC) describes a method of health care programming that specifically addresses the health needs and priorities of a defined community. Professional literature typically outlines four functions of the COPC process: defining and characterizing the community; identifying community health problems; modifying health programs; and monitoring the effects of program modifications (Nutting, 1986). In 1993, with the COPC model in mind, community members in association with the Juneau County University of Wisconsin-Extension Service and the Mile Bluff Clinic initiated the organization of the Community Health Improvement Project (CHIP). One of CHIP's primary goals was to explore the applications of the COPC model in the rural area of Mauston, Wis.

There are no small victories in the fight against heart disease.
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To begin characterizing this community and identifying their major health and wellness problems, a WReN-sponsored research assistant worked with CHIP on three summer projects. The first project involved compiling epidemiological and census information from a variety of public reports on Juneau County and the Mauston area. The second project included informal observations of a primary care practice in the Mauston area. Finally, the third project entailed a telephone survey of the community's "concern-information-participation" (CIP) indexes.

The CIP index, based on a study conducted in Dearborn, Mich, incorporates the first and second COPC functions of the above model. In essence, the CIP index measures the degree of community "concern" for health issues, the desire for more health "information," and the willingness to "participate" in community health programs (Lichter, et al 1986). Similar to the Dearborn study, the Mauston CHIP survey used the CIP index to define the community's perspective on health and wellness issues. Furthermore, the CIP index measures the potential success of future health and wellness programming. A second survey simultaneously studied the medical professional's perspectives on Mauston's health and wellness issues. CHIP will apply the results of both surveys to future health programming and information services.

The core of the summer's activities was to construct a basis from which the CHIP committee could continue fulfilling the four functions of the COPC model as they ultimately work toward their goal of a healthier Mauston community.

Send inquiries to: James Logan, MD, Mile Bluff Clinic, 1040 Division St, Mauston, WI 53948.

Effects of a dietary intervention on total serum cholesterol in a community practice

Donald A Pine, MD, and Mary Sauser, Minnetonka, Minn

THE PURPOSE OF this study was to evaluate the effect of an intervention for patients at risk due to total serum cholesterol (TC) in a six-physician suburban practice. The program, used routinely in the practice since 1987, includes two or three counseling sessions with an office nurse. The nurse uses an eating pattern assessment tool (EPAT) to assess eating habits, and then provides handouts with brand-specific food advice.

Methods
Intervention patients were matched individually for sex, age, baseline TC, and time of TC measurement with other patients in the practice (n=98 in both intervention and comparison groups). Each intervention subject and their matched comparison subject returned for a 1- or 2-year follow-up.

Results
EPAT scores, indicating fat intake, demonstrated that intervention patients were following a step-1 diet at baseline. The 1-year study demonstrated a 3.9% and 2.2% TC decline in intervention and comparison groups respectively. TC decline (percent) was 2.9% (intervention) and 5.1% (comparison) in the 2-year study. TC decline did not differ significantly when intervention and comparison groups were compared.

Conclusions
Failure of TC to improve suggests that more follow-up and reinforcement is necessary when patients on a step-1 diet attempt to lower TC by reducing dietary fat.

Send inquiries to: Donald A. Pine, MD, 17821 Highway 7, Minnetonka, MN 55345.

A comparison of labor and delivery management between nurse midwives and family physicians

William J. Hueston, MD, Eau Claire

PRACTICE ASSOCIATIONS between family physicians and nurse midwives have been suggested as a means to increase the availability of obstetric care in rural areas. This study examines the labor and delivery management styles of these types of providers to determine if practice compatibility between family physicians and nurse midwives is a viable expectation.

Methods
Data was collected through a retrospective chart audit of a random sample of patients delivered at St Claire Medical Center in 1990 and 1991.

Results
Other than a more frequent use of narcotic analgesia in labor by nurse midwives, no significant differences in labor management were noted. When delivery was examined, it was found that nurse midwives more often achieved a vaginal delivery and did so without an episiotomy. In particular, there was an increase in the diagnosis of dystocia among patients of family physicians which led to an increased cesarean section rate.

Conclusions
Family physicians and nurse midwives manage labor similarly. Obstetric outcomes, however, differed for the patients of these two groups of providers. These outcome differences may not interfere with collaboration between family physicians and nurse midwives, but suggest that more subtle practice variations do exist.

Send inquiries to: William J. Hueston, MD, Eau Claire Family Practice Residency, 807 S Farwell, Eau Claire, WI 54701.

Emotional and financial costs and terminal care: A pilot study of critical incident debriefing for family practice physicians

Todd Swanson, MD, and John Schneider, PhD, Eau Claire

THE PURPOSE OF this study is: to develop more effective and humane ways to deal with the grief and loss that result from "critical incidents" in the family practice setting; and to look for more effective ways to contain health care costs associated with the last year of life. This study will use both the qualitative, or long interview method, along with a quantitative research technique using the "response to loss" (RTL) short form. Both of these instruments will be used to identify "critical incidents" and physician response to those incidents in the practice of five family physicians in and around Eau Claire.

Send inquiries to: John Schneider, PhD, Eau Claire Family Practice Residency, 807 S Farwell, Eau Claire, WI 54701.

A solo physician's office tracking teenage behaviors with regard to drugs, alcohol, cigarettes, and sex

Terry L. Hankey, MD, Waupaca

THIS PAPER REPORTS the results of a pilot project conducted in a solo family physician's office. The purpose of the project is to track individual teenage patients with regard to development of attitudes and behavior with regard to four high-risk behaviors. The specific behaviors monitored were related to drugs, alcohol, cigarettes, and sex.

There was felt to be a need in this practice to identify the stage of development for each patient without a specific system to track patients and identify their stage of development. It is impossible to provide patient education material appropriate to their needs. A four-part system was developed that included a letter to the teenager, a letter to the parent of the teenager, a flow sheet that is kept on the chart, and a score card for risky behavior, which is given to the teenager at an office visit at least once each year. Specific questions are asked on the score card to identify the stage of development. This stage is marked on the flow sheet and at each visit, appropriate information is sent.

Methods

In an effort to test the forms and the system, the forms were used for 10 teenage patients at routine office visits. The patients were identified consecutively so that there was no selection bias.

Results

With regard to forms design, several problems were identified, including the need for a space for date, name, and a notes section and also the need for reporting bad consequences of risky behaviors (one patient was already pregnant because of high-risk sexual behavior and there was no convenient place to record this on the flow sheet).

With regard to the score sheet, some wording changes were required. It was learned that early teenagers confuse stage five (mature resolved non-user) with stage two (non-participant, has information, non-user). As a result of the pilot, it was determined that any teenager under 17 who marked a stage five would be scored as a stage two.

Identifying patient information materials that was appropriate was found to be a problem. The pilot study identified lack of appropriate patient education materials for several stages. The pilot indicated that the material must not only be appropriate by topic and stage of progression, but also the stage of teenage development (early, middle, and late) and also Tanner stage (I-V).

As a result of the pilot project on

only ten patient visits, four high-risk teenagers were identified. As a result, 21 pieces of age- and stage-appropriate literature were sent. The earliest risky behavior was cigarette smoking at age 12, followed by the remaining drugs, alcohol, and sexual behavior at age 15.

Even though the pilot was small, it raises questions to stimulate further research. Can delay in the non-participant stage into late teens be a problem? What is really required to go from non-participant to mature stage of development (experience, challenge, temptation, living with convictions for a period of time)? There seemed to be similarities between siblings in the same family (even male and female) with respect to risky behaviors. Can we identify family traits that lead to high-risk teenage behavior? Based on this pilot project, I hope to stimulate an interest in full scale implementation of this system with research into long-term tracking.

Send inquiries to: Terry L. Hankey, MD, 900 Riverside Dr, Waupaca, WI 54981.

Effects of non-traditional residents on family practice curricula

Randolph B. Waskin, MD, and William G. Elder, Jr., PhD, Wausau

THIS STUDY examines the recent phenomenon of non-traditional residents in family practice residencies. Particular emphasis was placed on evaluating the effect these residents had on curricula. Non-traditional residents were defined as those residents entering family practice residency with 1 or more years of prior practice experience, rather than matriculating directly from medical school. This study sought to determine the number of non-traditional residents in the United States to measure the level of perceived need for curriculum modifications, to accommodate these residents' needs, and to investigate curricular changes which may be desirable. Data were collected by mailing questionnaires to each family practice residency program director in the United States. Likert scale questions were used to allow analysis of the relative strength of the respondents' opinions. Results will be presented regarding the number of non-traditional residents nationwide and their geographic distribution, as well as program directors' opinions regarding desirable curricular changes.

Send inquiries to: Randolph B. Waskin, MD, Wausau Family Practice Center, 995 Campus Dr, Wausau, WI 54401.

Practical field studies in family practice: blastomycosis

Dennis J. Baumgardner, MD, and Daniel P. Paretsky, DVM, Milwaukee

USING AN EXAMPLE of ongoing epidemiologic research on blastomycosis (a significant health problem in Wisconsin) the opportunity, ease and approach of incorporation of field work and simple laboratory research into a family practice are presented.

For blastomycosis and many diseases, investigation of cases resulting from unusual, brief or highly restricted exposure may lead to discovery of epidemiologic risk factors. In this case, a canine confined to an outdoor kennel and yard acquired blastomycosis during winter.

Methods

The dog owner was interviewed and the site visited. A hypothesis of exposure opportunity was formulated based on the literature and previous research. Soil sampling using a simple 37° centigrade in-vitro enrichment technique devised

in our laboratory was attempted. Suspicious fungal isolates were tested for thermal dimorphism using a yeast extract-glucose-Tween 80 medium which we devised.

Results

The dog resided within 1/8 mile of the Wisconsin River. Site visit revealed that the dog was housed 75 feet downwind of a pigeon coop which was soiled with bird droppings. A dense grove of Norway Pine under which birds were fed was adjacent to the coop. These areas were considered likely exposure sites based on knowledge of enrichment of Blastomyces by bird droppings, the type of soil which was present, association with conifers, proximity to a riverbank, and lack of snow cover. Soil samples obtained from the coop and beneath the pine trees in April and June 1993 failed to reveal Balstomyces dermatitidis, and were hampered by background soil fungi and actinomycetes. (A similar enrichment technique did result in isolation of *B.dermatitidis* seeded into similar, previously frozen unsterilized soil.)

Conclusions

Field studies are interesting (and fun!) and can be easily incorporated into a family practice.

Send inquiries to: Dennis J. Baumgardner, MD, St Luke's Family Practice Residency, 2901 W Kinnickinnic River Parkway, Suite 175, Milwaukee, WI 53215.

Effects of third-year clerkships on residency selection

Charles Gessert, MD; Mark Gottlieb, PhD; Phil Fulkerson, MD; and Mahendr Kochar, MD, Milwaukee

In view of increasing interest in encouraging new medical school graduates to enter primary care specialties, we evaluated whether the sequence in which medical students proceed through traditional clerkships affects the selection of residency specialty. Our hypothesis was: Initial third-year clinical rotations are disproportionately influential in subsequent residency selection. That is, we hypothesized that initial clinical experiences are disproportionately important in the formation of medical students' clinical confidence and in shaping their internal identity as clinicians.

Methods

Data from 930 medical students' records of third-year rotations during 1981-1982 through 1984-1985 were linked to AAMC records of postgraduate residency activity. Six initial clerkship rotations were compared in terms of their proportional distribution among primary care residency specialties. Postgraduate (PG) 1 year residency was used for classification, with PG2 choice used when the PG1 residency was "Flex" or where a PG1 to PG2 shift pattern indicated that an internal medicine PG1 rotation was being used in a "Flex" manner. Chi-square analysis was performed to evaluate whether significant deviations from the expected proportional distribution of students between first clerkship rotation and residency specialty occurred.

Results

The table below summarizes our major findings.

First	#	% Primary care	P
medicine	158	58.9	0.66
pediatrics	276	56.5	0.75
psych/ophth	168	53.6	0.28
surgery	149	63.1	0.12
ob/gyn	151	60.3	0.42
anesthesia	27	33.3	0.01
Total	930	57.3	

Conclusions

Little evidence was found to support our hypothesis that the order of clerkship rotations influences subsequent entry into primary care residencies. Subsequent studies should examine larger numbers of students and targeted groups of students, such as "undecided," or by age, gender, etc.

Send inquiries to: Charles E. Gessert, MD, Medical College of Wisconsin, 8701 Watertown Plank Rd, Milwaukee, WI 53226.

Obesity and visits to the doctor's office

Cheri L. Olson, MD; Howard D. Schumaker, MD; and Barbara P. Yawn, MD, La Crosse

Obesity is a major health risk in the United States, yet physicians and patients alike are frustrated by weight issues in clinical practice. The purpose of this study was to determine if patients delay or avoid health care due to the need to be weighed when they go to the doctor. A cohort study of female nurses, unit coordinators, and nursing assistants was done using a survey. Analysis of 310 surveys showed that 12.6% of women had delayed or cancelled a doctors appointment, and an additional 2.6% refused to be weighed at their office visit. The most common reasons for delaying the physician visit was embarrassment about their weight, planning to lose weight before seeing the physician, and not wanting a lecture. Using logistic regression analysis, cancelling or delaying a doctors appointment was statistically significantly related to increasing body mass index.

In conclusion, female hospital employees commonly delay or cancel medical care due to concerns about their weight.

Send inquiries to: Cheri L. Olson, MD, St Francis-Mayo Family Practice Residency, 700 West Avenue S, La Crosse, WI 54601.

Comparison of women's satisfaction with Norplant and oral contraceptives

Gayleen M. Eilers, MD, and Todd Swanson, MD, Eau Claire

The Norplant contraceptive was introduced in the United States in January 1991. It is one of the most effective reversible methods of contraception with a cumulative pregnancy rate of 0.8 per 100 users over 5 years. The Family Medicine Clinic is a leader in this form of reproductive technology in the Eau Claire area. We have conducted three training seminars for physicians on insertion and removal of the Norplant device. Since May 1991, 115 patients have undergone Norplant insertion in our clinic.

Because this is a relatively new contraceptive, the only current available information on patient acceptance is in large drug company studies and more recently a Planned Parenthood study. This study compares Norplant users to a comparable group of oral contraceptive users in a family practice clinic to determine:

- How satisfied are Norplant and oral contraceptive users with their method of contraception?
- What are the benefits and disadvantages identified by women using Norplant and oral contraceptives?
- Would Norplant and oral contraceptive users choose their method of birth control again?

Methods

All 115 patients who have had Norplant inserted in the Family Medicine Clinic will be included in the study. We randomly selected a similar group of oral contraceptive users. Our study questionnaire asks demographic data, contraceptive history, specific benefits and problems the women encountered, whether they are satisfied with their choice of contraceptive, and whether they would choose the same method of contraception again. We mailed the survey questionnaire to the study participants. A follow-up card requesting the questionnaire be completed was sent the following week. We sent a second copy of the survey questionnaire to all participants who did not return their survey in 1 month. We then analyzed the data to evaluate, compare, and contrast Norplant and oral contraceptive users' satisfaction with their contraceptive.

Conclusions

In our study, the majority of Norplant and oral contraceptive respondents were satisfied with their contraceptive.

Send inquiries to: Gayleen M. Eilers, MD, Eau Claire Family Practice Residency, 807 S Farwell, Eau Claire, WI 54701.

Asthma prevalence and age at onset in Wisconsin Research Network practices

David L. Hahn, MD, and John W. Beasley, MD, Madison

THE WISCONSIN RESEARCH Network (WReN), a group of primary care practice sites interested in office-based research, surveyed outpatients to identify diagnosed asthma or possible undiagnosed asthma (wheezing and shortness of breath). Here we report patient characteristics, prevalence and age at onset of disease.

Methods
Between August 1992 and July 1993, 59 WReN practices interviewed a systematic sample of their clinical population (all patients encountered during office visits one day each week for 3 or 12 months). Data collected included age, sex, history of physician-diagnosed asthma or undiagnosed wheezing and shortness of breath (possible asthma), age at onset of diagnosis or symptoms, and whether symptoms were active in the past year.

Results
The age and sex composition of the 14,127 patients surveyed closely resembled that of the general practice/family practice component of the National Ambulatory Medical Care Survey, a random sample of general and family practices in the United States. Active asthma was reported by 6.1% and possible asthma was reported by 3.3%. Elderly males reported more possible asthma than other males. Young males had more asthma than young females, and young adult and middle-aged females had more asthma than their male counterparts, which are patterns reported in most asthma prevalence studies. Adult-onset asthma and possible asthma were as commonly reported as childhood-onset asthma.

Conclusions
The age and sex composition of WReN practices is representative of other clinical populations throughout the United States. The distributions of asthma prevalence and age at onset were similar to most previous studies reported for western populations. WReN practices are suitable "laboratories" in which to study asthma.

Send inquiries to: David Hahn, MD, Arcand Park Clinic, 3434 E Washington Ave, Madison, WI 53704.Asthma prevalence and age at onset in Wisconsin Research Network practices

Socioeconomic bias in the use of epidural anesthesia in labor

William J. Hueston, MD; Richard R. McClaflin, MD; Christopher Mansfield, PhD; and Mary Rudy, MA, Eau Claire

THE USE OF MEDICAL SERVICES is sometimes influenced by patient socioeconomic factors and physician or provider characteristics. This study examined the influence of these factors on use of epidural anesthesia in labor.

Methods
A retrospective review of a randomized set of deliveries during 1990 and 1991 was performed at five hospitals. A total of 8,229 deliveries were reviewed, and patients were classified according to insurance status, race, age, parity, location of residence (rural or urban), and specialty of obstetric provider.

Results
Primiparous women were more likely to use epidural anesthesia during labor. When stratified for parity, epidural use was associated with private insurance, white race, older age, and obstetric care from an obstetrician. Logistic regression showed that obstetrician care, private insurance, and white race were independently associated with use of an epidural.

Conclusions
Epidural anesthesia appears to be used more frequently by white women with insurance who obtain their care from obstetricians. This may represent a socioeconomic bias in the delivery of this service and may be influenced by greater use of technology by non-generalist physicians.

Send inquiries to: William J. Hueston, MD, Eau Claire Family Practice Residency, 807 S Farwell, Eau Claire, WI 54701.

Cardiac risk factor outcomes in a phase-III rehabilitation program

John E. Laabs, MD and Penny L. Claggett, MS, Neenah

THIS STUDY COMPARES the cardiac risk factor outcomes of long-term participants in a phase III rehabilitation program with non-participants who had similar follow-up at the same health screening facility.

Both groups were similar in characteristics before entering the phase III program. Participants, however, exercised more frequently and had lower serum triglyceride levels before beginning the program. After almost 6 years average enrollment time, participants continued to exercise significantly more often ($p=0.02$), had higher serum HDL-cholesterol levels ($p<0.001$), and had lower total cholesterol/HDL-cholesterol ratios ($p<0.01$) when compared to the non-participant group after adjustment for age, sex, and time in the program.

Other risk factors--including blood pressure levels, weight, body fat, smoking habits, and fitness (measured with maximum VO2)--did not vary significantly between the groups at the end of the study.

The results suggest that active participation in a phase III program independently affects cardiac risk factor modification outcomes. The findings that a large number of enrollees do not participate and that some risk factors are not affected by participation can be used to formulate strategies of management and evaluation of a long-term rehabilitation program.

Send inquiries to: John E. Laabs, MD, Kimberly-Clark Corporation, 2100 Winchester Rd, Neenah, WI 54956.

Trial of physician intervention of problem drinkers

Michael Fleming, MD; Kristen Barry, PhD; and Linda Manwell, BA, Madison

THIS TRIAL IS designed to test the effect of brief physician advice on the alcohol-related behaviors and health status of problem drinkers. Subjects are selected from the practices of 70 primary care physicians located in the Milwaukee and Dane County areas. Approximately 500 patients from each physician's practice with regularly scheduled appointments complete an imbedded alcohol screening instrument that contains questions on smoking, weight loss, exercise, and alcohol use.

This trial is focused on the treatment of adult problem drinkers, defined as male subjects who drink more than 15 drinks per week or female subjects who drink more than 12 drinks per week. Following a face-to-face interview with a researcher, subjects are randomly assigned to an experimental or control group. The experimental group is exposed to a standardized intervention protocol administered by their physicians. This protocol includes a diagnostic interview, a brief counseling session, a self-help manual, a prescrip-

tion to change drinking habits, and a followup visit.

Fourteen outcome variables have been selected based on the findings of completed clinical trials:

- number of weeks of sobriety;
- number of episodes of binge drinking;
- alcohol use 7 days prior to 6- and 12-month follow-up telephone interviews;
- days of hospitalization;
- sick days;
- injuries and accidents;
- emergency room visits;
- legal events;
- global perception of health;
- number of outpatient visits;
- number of prescriptions;
- self-reported health status;
- family relationships; and
- number of chronic illness visits.

The outcome variables are assessed by self-report telephone interviews at 6 and 12 months, and a telephone interview with a family member at 12 months. Progress to date will be reported.

Send inquiries to: Michael Fleming, MD, Department of Family Medicine, University of Wisconsin Medical School, 777 S Mills St, Madison, WI 53715.

Resuscitative methods and outcomes in a small community hospital

Dan Fifield, MD, Wild Rose

The initiation of cardiopulmonary resuscitation on a widespread basis began after Knickerbocker and Kouwenhoven (*JAMA*.1960:173: 1064-1067) published results of their efforts. The success of resuscitation efforts have since been examined during the intervening two decades and, recently, the value of these interventions has been questioned with regards to short and long term outcomes.

With the exception of Medford's study (*W Virginia Med J*.1966: 62(2):43-46), little has been done to quantify outcomes of resuscitation efforts in small community hospitals, and lacking clear data for anticipating outcomes of interventions, we felt it necessary to evaluate our performance for comparison to broader surveys as they develop.

A retrospective study was performed at Wild Rose Community Memorial Hospital, a 29-bed acute care facility in a rural area of Wisconsin. Fifteen resuscitations were examined which constituted all in-house codes called from July 1991 through July 1993. Three of the codes were called on one patient during two separate hospitalizations. Another code involved a 32 week EGA neonate born precipitously at home and transported by emergency medical personnel. Otherwise all resuscitations involved individual patients and occurred either in the hospital or on hospital grounds.

Codes are defined as loss of spontaneous respirations, perfusing heart rhythm, or unmeasurably low blood pressure.

Staff interviews and chart reviews were conducted for our data base.

Of the patients resuscitated, only 2 (15%) did not survive initial resuscitative efforts; 7 (54%) died prior to discharge, in a time ranging from 2 days to 2 months; 4 (31%) survived to discharge and are currently alive. Further results will be discussed.

Comparison of data would indicate favorable outcomes when compared to previous studies. Bias is certainly introduced in the motivation for this retrospective, in that the initial observation that "a lot of people seem to survive their codes here," is what prompted this investigation.

Thirteen patients and 15 events do not constitute a sufficient statistical base to work with in regards to factors influencing outcomes. What can be stated is that the small size of our facility precludes the possibility of an unwitnessed arrest. All of our events were witnessed and resuscitation started in less than a minute, usually with all equipment and personnel in place.

Resuscitative methods and outcomes will continue to be followed at our institution and comparisons made with other hospitals in an effort to identify developing trends.

Send inquiries to: Dan Fifield, MD, PO Box 314, Wild Rose, WI 54984.

Attrition from family practice residencies

Herbert F. Laufenburg, MD; Nick W. Turkal, MD; and Dennis J. Baumgardner, MD, Milwaukee

Attrition of residents from family practice programs causes significant problems for faculty, residents, and patients. The literature contains little information about predicting attrition based on application data.

Methods
Surveys were sent to 394 family practice residency program directors asking them to calculate their attrition rate for a 10-year period, and to classify their type of program and the type of residents who left the program.

Results
Of US residencies, 41.6% submitted responses that were interpretable. The survey revealed an overall 8.6% attrition rate. Of those leaving, 63% did so for other specialties. Residents leaving most often did so for other specialties, and international medical graduates taken outside of the match were most likely to leave the program before completion.

Conclusions
During a period of time of declining interest in family medicine, residency directors may frequently need to consider applicants from outside of the match pool. Data from the survey may be helpful in predicting those residents who are more likely to complete the residency training.

Send inquiries to: Herbert F. Laufenburg, MD, St Luke's Family Practice Residency, 2901 W Kinnickinnic River Parkway, Suite 175, Milwaukee, WI 53215.

Immunization use by family physicians: preliminary report of a national study

William J. Hueston, MD; Arch G. Mainous III, PhD; and J. Brad Farrell, BS, Eau Claire

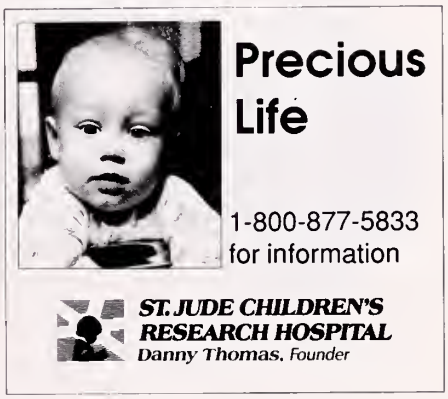
Previous reports suggest that rural family physicians include routine childhood immunizations less frequently in their practices. Many of these physicians have discontinued immunization practices in their offices because of the expense of vaccines.

Methods
A survey was performed using a random sample of practicing family physicians in six states. States that provided immunizations to physicians free of charge were matched with those that did not participate in this program. Pairs of states were chosen from differing census tracts to increase the geographic variability of the sample. Physicians were asked whether they provided immunizations in their offices and whether they limited this practice to certain populations. Knowledge about immunization indications and contraindications and attitudes about immunizations were also queried.

Results
Preliminary results of the survey will be presented from states which have completed the survey.

Conclusions
We hope that this survey will give some insights into immunization use in private practice. This may be useful in adopting federal policies for immunization distribution and administration.

Send inquiries to: William J. Hueston, MD, Eau Claire Family Practice Residency, 807 S Farwell, Eau Claire, WI 54701.



Epidemiology of canine blastomycosis in northcentral Wisconsin

Dennis J. Baumgardner, MD; Daniel P. Paretsky, DVM; and Adam Yopp, Milwaukee

Blastomycosis is highly endemic in northcentral Wisconsin where it is a significant human and canine health problem. We recently reported a descriptive study of 73 human blastomycosis cases from this region that suggested that place of residence (proximity to waterways) was a greater risk for blastomycosis than activities. Canine blastomycosis cases are harbingers of human disease and are more amenable to controlled studies of risk factors.

Methods

A case-control study examined epidemiologic features of all cases of canine blastomycosis from a single veterinary practice in Eagle River, Wis over a 3-year period. Control subjects included: all porcupine quill-injured canines during this time (outdoor exposed dogs); and every sixth dog receiving rabies vaccination during the second year of study (representative of all dogs in the practice). Cases were entered prospectively and examined retrospectively by owner interview.

Results

The estimated mean annual incidence of canine blastomycosis in this region was 1,000/100,000. Data thus far (32/36 months completed) reveals that blastomycosis cases were younger and more often male than the vaccine control dogs but similar in age and sex to quill-injured dogs. Blastomycosis cases were significantly more likely to reside within 1/4 mile of a waterway (95%) than quill-injured dogs (66%, $p<.001$) or vaccinated dogs (74%, $p<.01$). Exposure to excavation was significantly more likely among blastomycosis cases compared to quill-injured canines, however, no differences were found for hunting, swimming and reported beaver exposure. Geographic clustering of canine cases is similar to that previously reported for human cases.

Conclusion

Northcentral Wisconsin is very highly endemic for canine blastomycosis, paralleling the incidence and geographic distribution previously described for humans. Close proximity to waterways and exposure to excavation are significant risk factors for blastomycosis.

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Public health
Preventable causes of death in Wisconsin

Patrick L. Remington, MD, MPH, Madison

In this century, there has been a dramatic shift in the causes of death and disability. In 1900, the major causes of death were infectious diseases such as pneumonia, tuberculosis, and diarrhea.[1] Today, chronic diseases such as heart disease, cancer, stroke, and diabetes account for more than 70% of the deaths annually (Table 1).

Although information from death certificates has been used to document this shift, this data provides little insight regarding the preventable causes of death in the population. For example, information concerning cigarette smoking and alcohol use is rarely mentioned on the death certificate, while the role of other important behavioral risk factors, such as diet and physical activity, is never recorded.

Methods

In this report, the major preventable risk factors that contribute to death in Wisconsin are identified using three sources. First, when available, data on risk factors were obtained from Wisconsin death certificates (eg, the number of deaths caused by firearms). If this information was not available (eg, cigarette smoking is not typically recorded on the death certificate as a contributing cause), estimates were obtained from previously published studies of the contribution of these factors to deaths in the state.[2-5] Finally, if no state-specific studies had been published, estimates were made using results of a recent study by McGinnis and Foege.[6]

In their study, McGinnis and Foege reviewed articles published between 1977 and 1993 that used quantitative methods to assess the relative contributions of risk factors in the development of major diseases (ie, the proportion of a particular disease caused by a specific risk factor). For the factors of greatest complexity and uncertainty, a conservative approach was taken by choosing the lower boundary of the various estimates. In the current studies, these proportions were applied to the Wisconsin death certificate data for 1992, and rounded to the nearest 100.

Results

Approximately 50% of the deaths each year in Wisconsin result from nine preventable risk factors (Table 2). For Wisconsin, this represents approximately 21,100 deaths each year.

Tobacco. According to previously published studies, tobacco use accounts for approximately 8,700 deaths annually in Wisconsin,[2-4] contributing substantially to deaths from cardiovascular disease, cancer, lung disease, low birth weight, and burns. This estimate includes 776 deaths attributable to the effects of

Continued on next page

Table 1.—Ten leading causes of death in Wisconsin, 1992.*

Cause of death	Number
Heart disease	14,028
Cancer	10,310
Stroke	3,314
Chronic lung disease	1,635
Unintentional injuries	1,572
Pneumonia and influenze	1,570
Diabetes mellitus	1,043
Other arterial diseases	607
Suicide	584
Nephritis/nephrosis	422
All other causes	7,094
Total	42,179

*From the Center for Health Statistics, Division of Health, Wisconsin Department of Health and Social Services.

The public health column is not reviewed by the *WMJ* editorial board. From the Bureau of Public Health, Wisconsin Division of Health. Dr Remington is the chief medical officer for chronic disease control. Reprint requests to Patrick L. Remington, MD, Wisconsin Division of Health, 1400 E Washington Ave, Room 228, Madison, WI 53703.

Continued from preceding page
environmental tobacco smoke.

Diet and physical inactivity. Based on national estimates, poor diet and physical inactivity account for approximately 5,900 deaths annually in Wisconsin. These two factors are interrelated, and contribute to deaths from cardiovascular disease, cancer, and diabetes. Poor diet and physical inactivity are not listed as contributing factors on death certificates and no studies have been published in Wisconsin.

Alcohol. According to a previously published study, alcohol misuse accounts for approximately 1,900 deaths annually in Wisconsin,[5] contributing to deaths from injuries, cancer, cardiovascular disease, and liver and other digestive diseases. Not included in this estimate are the substantial health, social, and economic costs of alcoholism and alcohol abuse. Alcohol misuse is seldom listed as a contributing cause of death. Of the estimated 1,900 annual deaths, the role of alcohol is mentioned specifically on about 300 (eg, alcoholic cirrhosis of the liver).

Microbial agents. Microbial agents account for approximately 1,500 deaths annually in Wisconsin. This represents the sum of the deaths from infectious and parasitic diseases, meningitis and encephalitis, and pneumonia and influenza (2,043 deaths in 1992); less those otherwise attributable to tobacco, alcohol, and careless sexual behavior (approximately 500 deaths annually).[2,5]

Toxic agents. Based on national estimates, toxic agents account for approximately 1,200 deaths annually in Wisconsin, contributing to deaths from cancer and other diseases of the heart, lungs, liver, kidneys, bladder, and neurologic system. Environmental factors include occupational hazards, environmental pollutants, and contaminants of food and water supplies. As noted by McGinnis and Foege, however, this may be the most uncertain estimate, because a wide variation in prior study techniques and because the recognition of the potential health effects is still evolving.

Table 2.—Preventable causes of death in Wisconsin.

Cause	Attributable fraction (range)*	Estimated number
Tobacco	21 (12-22)	8,700
Diet and activity patterns	14 (14-27)	5,900
Alcohol misuse	5 (3-5)	1,900
Microbial agents	4 --	1,500
Toxic agents	3 (3-5)	1,200
Sexual behavior	1 --	600
Firearms	1 --	500
Motor vehicles	<1 --	400
Illicit use of drugs	<1 --	400
Total	50	21,000

*Adapted from McGinnis and Foege.[6]

Sexual behavior. Based on national estimates, careless sexual behavior accounts for approximately 600 deaths annually in Wisconsin, contributing to deaths among infants and from cervical cancer, hepatitis B, and HIV. According to McGinnis, unprotected intercourse represents one of the most rapidly increasing causes of death in the country. In Wisconsin, a majority of the deaths from HIV and hepatitis are related to sexual behavior (DHSS, unpublished data).

Firearms. Firearms are responsible for approximately 500 deaths annually in Wisconsin. In 1992, 464 deaths in Wisconsin listed firearms as an external cause of injury. Of these, 298 were from suicide and 144 from homicides. This estimate is slightly less than the 2% estimated nationally by McGinnis and Foege.[6]

Motor vehicles. Motor vehicle injuries to passengers and pedestrians account for approximately 400 deaths annually in Wisconsin. This estimate represents approximately 60% of the deaths due to motor vehicle injuries (667 in 1992) that are not otherwise attributed to alcohol misuse.[5] Many of these deaths are preventable through the use of lap and shoulder belts, airbags, child restraints, and motorcycle helmets.

Illicit use of drugs. Based on national estimates, illicit use of drugs accounts for approximately 400 deaths in 1992. Illicit drug use contributes to deaths from overdose, suicide, homicide, motor vehicle injury, HIV infection, pneumonia, hepatitis, and endocarditis. There are no published estimates of the total contribution of drugs to deaths in Wisconsin, and information about drug use is lacking in the death records.

Comment

Prevention is widely accepted as the most cost-effective way to improve the public's health. In this report, we find that half of the deaths in Wisconsin are directly related to only a few preventable causes. Although these estimates are based upon sev-

Continued on page 128

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Continued from page 126
eral assumptions, they nevertheless provide a basis upon which to develop prevention strategies.

By focusing on preventable causes of death, rather than on the traditional "underlying" causes, the importance of prevention strategies becomes obvious. Tobacco and alcohol account for over half of the preventable deaths each year. Most of the remaining deaths result from other behaviors, including poor diet and physical inactivity, careless sexual practices, and failure to use seatbelts. Prevention initiatives must not only increase knowledge of the importance of these health behaviors, but also provide the skills and environment necessary to choose and maintain healthy lifestyles.

This report also points out major limitations in existing death records. Death certificates list the diseases or conditions that eventually lead to death, but invariably lack information about behavioral, environmental, or occupational risk factors. For example, whereas epidemiologic evidence suggests that smoking causes at least 80% of lung disease, it was mentioned as a contributing cause in only 7% of these death certificates in Wisconsin in 1990.[7] Physicians are uniquely positioned--through proper and complete death certification--to define the role of these important preventable risk factors in causing premature deaths.

While considerable progress has been made over the past several decades in improving the public's health, many challenges remain. Cigarette smoking rates among youth have not changed over the past decade and rates among women have declined only slightly.[8] Firearm-related deaths and sexually transmitted diseases, such as AIDS, tuberculosis, and syphilis are increasing at an alarming rate.[9] Shifting the focus from *diseases* as causes of death--to *preventable risk factors*--will help focus future prevention initiatives.

Acknowledgments
Ray Nashold, Susan Wood, and Mat Reeves provided helpful suggestions and comments.

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PCF board approves 7.1% PCF fee increase, WHCLIP reduction

The Board of Governors for the Patients Compensation Fund/WHCLIP has approved a 7.1% increase in fund fee assessments. The SMS Executive Committee submitted a recommendation to the PCF board in advance of its Feb 23 meeting, requesting the board support a recommendation offered by the fund's actuarial and underwriting committee, which would hold the fee increase to 5.4%, the 1993 CPI medical component rate of increase.

The PCF fee changes will be as follows: class 1--from $2,941 to $3,150; class 2--from $5,883 to $6,300; class 3--from $14,705 to $15,750; and class 4, from $17,646 to $18,900. The board also approved an overall 4% reduction in premium for physicians in the WHCLIP, with variations within physician classes. Both changes are effective July 1, 1994.❖

AMA candidate Tim Flaherty, MD, tackles issues facing physicians

Shari Hamilton, assistant editor

***WMJ:* Looking into the proverbial crystal ball, what do you see as the most significant differences between the medical profession of today and the medical profession of five years from now?**

FLAHERTY: The big differences will be dictated by the consequences of national and state attempts at health system reform and their effects on the medical profession. Currently, the threat of health system reform linked with the corporate rush to managed care is already resulting in an unprecedented rush to integrate physicians into larger groups and a variety of health systems. We can expect to see that state of flux persist as the uncertainty over reforms continues, and reforms are implemented and, subsequently, modified.

***WMJ:* What do you view as some of the pluses and negatives of integration?**

"We physicians need to maintain our right to choose the most appropriate treatments for our patients."

FLAHERTY: The biggest perceived threat to many physicians is that of being left out--whether it's being left out of an alliance, left out of a system, or left out of a managed care system. The perceived pluses are that you have strength in numbers, you have strength in organizational size, and you have, perhaps, not missed the opportunity to sell your practice to a larger entity.

But in many cases, the negatives stem from the same things as the pluses: you're in a big organization so there may be a loss of control or a loss of autonomy. Physicians--as I have known them during my practice time--tend to be individuals and that individuality manifests itself in a variety of attitudes and actions. This individualism, however, I view as one of medicine's greatest strengths manifesting itself in the way physicians practice medicine and in the unique ways we approach our patients' problems.

For many reasons, physicians now have a sense of being driven into practice conformity. Physicians understand the use of practice guidelines or practice parameters. But, we also tend to want to be on the cutting edge, and certainly, we want to do what is best for our patients. We physicians want to, and need to, maintain our right to choose the most appropriate treatments for our patients.

Many pressures on physicians involve initiatives to save health care dollars, and I believe physicians have the right and responsibility to ensure that so-called dollar-saving techniques do not jeopardize the quality of patient care.

A concern I have for the medical profession as a whole is that some physicians are now integrating into systems that they will be very uncomfortable with later, whether it's one year, five years or 10 years down the road.

***WMJ:* Will these integrated systems result in any cost savings for patients? Will administrative costs be reduced?**

FLAHERTY: To a major extent, the dramatic escalation in administrative costs can be attributed to the government and private insurance companies' blizzard of forms and requirements, snowing down on practicing physicians. Simplification and standardization of insurance forms and the repeal of repressive--and in many cases, ridiculous--government regulations could produce tremendous savings in administrative costs.

Certainly, system integration has the potential to reduce administrative costs. The magnitude of such savings will vary greatly, depending on the circumstances of practice, before and after integration.

***WMJ:* We keep hearing about the necessity of reducing costs. Where could we realize some real cost savings in the health care system?**

"First of all. . . responsibility for personal actions must be emphasized."

FLAHERTY: First of all, as President Clinton has related, responsibility for personal actions must be emphasized and incorporated into the American social fabric. Drug abuse, family violence and other violent crimes, and our epidemic of HIV infections can all be minimized by increasing personal responsibility. The AMA has stressed increasing competition in the medical marketplace as a cost containment method. This approach requires both employers and insurers to offer individuals a choice of health plans and financing mechanisms, thus encouraging patients to make cost-conscious decisions. Meaningful and major professional liability reform also has great potential to reduce defensive medicine costs as well as liability insurance premiums--costs that are ultimately passed on to patients.

The real cost savings of medicine--of the magnitude desired by the president and Congress--are only going to come by what Dr Willard Gaylin (co-founder of the Hastings Institute) calls "the ethic of restraint." Gaylin presents the very convincing argument that medicine is now suffering from its successes in that good medicine creates a sicker population.

In the United States where there is strong medical care, for example, you have many diabetic women having term pregnancies and delivering healthy babies where in a less-developed country diabetic women would either not carry fetuses to term or would have a great deal of difficulty during pregnancy because their diabetes wouldn't be well controlled. Here most diabetics successfully bear children, which results in a generic preponderance for diabetes. So ultimately, there are more people with diabetes in the United States than there are in an underdeveloped country. Our coronary by-pass surgery heightens the incidence of people who are living with heart disease so that population is higher than in underdeveloped countries where there wouldn't be that intervention. The list goes on.

The only way you save big money in our system, Gaylin argues, is to just

not deliver as much care. I believe those decisions must be societal decisions, however, not physician decisions. Some of the services society has to consider eliminating to save health care dollars involve the "care around the edges"--care for the babies that are born too early or those that some people think are living too long. Those are the areas in which we can realize significant health care savings; everything else is just window dressing. We see these types of decisions being made in countries with government-run system, either rationing by queing patients or by conscious decision to not, after a certain age, treat a disease or not attempt to resuscitate babies under a specific birth weight.

A concern I have with the whole reform effort is that the tough spending decisions are being transferred down to the physician level and the politicians are trying their best to insolate themselves from that responsibility. The Clinton plan transfers those decisions to the alliance level, or the insurance company level, and from there directly to the physician.

An important concern for physicians has to be our ability to respond to those policy movements as they occur. The AMA has to be ready to respond with action that is representative of physicians' interests and our ability to provide appropriate care for our patients.

***WMJ:* What do you see as the most important role for organized medicine during the "transition" years of health system reform?**

FLAHERTY: I think the most important role is representation at all levels--national, state and local. Whether you are reacting to a legislative issue from the national level or a regulatory issue, organized medicine has to be prepared. Regulatory issues are frequently more onerous than legislative issues so the AMA must continue its role of vigilant watch dog.

***WMJ:* What do you think should be the primary goals of physicians and organized medicine with regard to health system reform? What battles do you foresee on Capitol Hill?**

FLAHERTY: We all support the basics of Health Access America--universal access and coverage, a basic benefit plan and the other points included in the AMA system reform plan. These points have been developed from a broad base of consensus. I believe the issues of patient and physician choice are an absolute litmus test as far as the AMA is concerned. This runs counter to what is happening in many managed care plans where the freedom of choice for both patient and physician has been abrogated. What I see happening in

my area is that most recent requests for proposals from employers for managed care plans contain some kind of point-of-service option, allowing patients to go outside of the managed care group for a price.

I think physicians can expect to see a lot of action on Capitol Hill; there will be battles over many issues. I don't think we need to dread these exchanges; it's the individual plays that determine whether a game is good, not just the final score. We've got excellent footing. With Health Access America, the AMA has facilitated the inclusion of many physician-endorsed elements in a variety of health system reform legislation.

***WMJ:* What prompted you to run for a seat on the AMA Board of Trustees?**

FLAHERTY: I have been involved in all areas of organized medicine for a long time and I have served as an AMA delegate and on the AMPAC board since 1986. The AMA House of Delegates serves as the vehicle for democracy among physicians and I consider the role of AMA trustee as an extension of this grassroots representation.

This is a critical time for the house of medicine, there's no doubt. It's a time when physicians are going to have to invest a great deal of time and talent if medicine's voice is to remain strong. I am ready to make that investment. I see an opportunity to serve practicing physicians and, at the same time, ensure quality medical practice is preserved for the younger generation of physicians--one of whom is my son, Kevin, who is a YPS delegate. I want to give what I can to ensure a continuity of the ability of American physicians to provide care in a manner that is not only going to be rewarding for them, but conducive to providing the high quality care we do now.

"I have deep concerns about over-regulation and intrusive health care legislation."

Through my experiences on the AMPAC and WISPAC boards, I have witnessed the significant effect the legislative process--whether state or national--has on health care and how healthcare is delivered. I believe this is a time when my experiences in organized medicine will be valuable at the AMA trustee level.

***WMJ:* Do you have any particular agendas?**

FLAHERTY: I have no personal agenda. I think all physicians have an agenda for how we think medicine should be practiced, and I have deep concerns about overregulation and intrusive health care legislation. Passage of meaningful tort reform and anti-trust relief for physician contracting rank high on my priority list.

***WMJ:* What role do you hope to play on the AMA Board of Trustees?**

FLAHERTY: I think the experiences I bring will prove conducive to implementing sound health policy. I come from a state that has a number of large multi-specialty clinics and a significant number of patients in managed care plans. Yet, Wisconsin still has a strong combination of urban and rural practices with a number of physicians in solo practice or partnerships.

In my practice, I work in hospitals of 50 and 400 beds and I see both semi-urban and rural practitioners on a daily basis. I serve on medical staff executive committees, on hospital boards of trustees as well as on a holding company board that owns two hospitals and numerous physician practices so I have seen the integration from several perspectives.

I have been fortunate to serve on the board of directors for the Medical College of Wisconsin and as a director of the for-profit arm of the State Medical Society. I currently serve on the board of a regional bank and am a director for Goodwill Industries of northcentral Wisconsin--two windows that continually renew my appreciation of the essence of the strengths and needs of our communities. I have gained a strong understanding of the business side of medicine within its diverse settings. As a clinical faculty member for both of Wisconsin's medical schools, I continue to be involved in the training of young physicians and am keenly aware of how medical school facilities and departments function. I have 31 years in the military, both active duty and reserves, giving me insight into military and government medicine.

***WMJ:* What other skills will you bring to the AMA board?**

FLAHERTY: As a general diagnostic radiologist, I work daily with a cross-section of my fellow colleagues and practitioners in various disciplines. I have a very good sense of problems and concerns for various health care providers because of those intimate associations within rural, urban, university and non-university practice environments.

Within the AMA structure itself, I have a particular interest in the organizational side, i.e. budgets, financing, etc. I want to be sure members are getting the best bang for their bucks. I've been very involved in developing non-dues income for the state society with SMS Services and I will continue that focus with the AMA to ensure the quality efforts there remain important.

***WMJ:* Outside of health system reform, what other issues do you see the AMA Board of Trustees focusing on in the next two to three years?**

FLAHERTY: In addition to the gut issues, the regulatory and legislative issues, I think the challenge for the AMA in general, and AMA trustees in particular, is membership. Right now the membership is about 40-plus percent of the potential---that's pretty high for national organizations--but the membership needs to grow. We have too many physicians in this country who are standing on the sidelines and watching--sometimes cheering, sometimes booing the actions of the AMA--but who are not involved in the ballgame.

The best way to get physicians involved is through peer-to-peer membership activities. Those non-members really have to feel that they would be better served inside the house of medicine than outside the tent. Despite the

fact that they frequently slip under the protection of the tent and benefit from the initiatives the AMA provides, non-members fail to contribute vital dues dollar. We need to change that.

The thrust now of the AMA is to better serve all groups of physicians. They have focused on large groups and I think that's been a very good effort. In addition, there has to be continued focus on the cross-section to make sure some groups aren't forgotten. Certainly, we have to increase involvement of young physicians, women physicians, minority physicians and international medical graduates--those are all areas where membership activities have to be focused on giving value for membership.

Yet as other issues draw our attention away we cannot forget that the AMA is still given credit as the number one scientific organization in the country. Occasionally, that vital AMA function--which consumes a large part of the dues dollar--is overlooked as the news media scans for sexier issues.

Flaherty in brief

Timothy T. Flaherty, MD, is a candidate for election to the AMA Board of Trustees. Dr Flaherty's candidacy is endorsed by the State Medical Society of Wisconsin, the North Central Medical Conference, the American College of Radiology and the Radiological Society of North America.

Dr Flaherty is a vigorous and effective leader with high ideals, known for his diligence, vision, energy, and dedication to the profession of medicine. During his first term, Dr Flaherty will bring to the AMA board his diverse skills and experience gained from his leadership in organized medicine and service on numerous hospital, medical school and financial boards.

Dr Flaherty has served as a delegate to the AMA, beginning in 1984. He is a director for Physicians Insurance Company-Wisconsin and chair of its investment committee. He currently serves as secretary of the board of directors for AMPAC, the political arm of the AMA, and is a councillor for the American College of Radiology. Dr Flaherty is a past president of the State Medical Society of Wisconsin and currently chairs the Wisconsin Physicians Political Action Committee (WISPAC). He has been appointed to serve on the Governor's Task Force on Health Reform (WI); and is a director of the State Medical Society of Wisconsin's holding company and a past director (1988 to 1993) of the Medical College of Wisconsin. He currently serves on the board of a regional bank and as a director for Goodwill Industries of northcentral Wisconsin. Dr Flaherty has earned a reputation as an innovative and critical thinker.

A graduate of the Marquette University Medical College, Dr Flaherty completed his residency in radiology at the University of Wisconsin Hospitals, where he was named chief resident and American Cancer Society fellow. He is board certified. Dr Flaherty's clinical experience has included private and military medical practice. He has earned the rank of Major General USAF (Ret). Dr Flaherty practices in both a 50-bed rural hospital and a 400-bed urban hospital. He has held a clinical appointment at the Univ. of Wisconsin Health Science Center since entering private practice in 1968 and was appointed clinical professor of radiology in 1985. In 1986, he was appointed clinical professor of radiology for the Medical College of Wisconsin in Milwaukee.

Tim Flaherty is warmly welcomed as a popular and polished speaker. He has testified frequently on prospective legislation and is respected as a thoughtful and rational voice for health care reforms, patients and physicians. Dr Flaherty was awarded the SMSW Civic Leadership Award in 1988.

***WMJ:* What are your thoughts on the increasing development and implementation of practice parameters?**

FLAHERTY: This is a positive for medicine. It demands that physicians examine their practices retrospectively and prospectively. To focus on patient outcomes--outcomes research and outcomes numbers--you have to have a basis before you can determine if variations from parameters or guidelines would positively or negatively affect outcomes. Practice parameters do not equate with "cookbook medicine"; we've gotten beyond that terminology. Now the concerns of physicians are not with practice parameters but with limitations of practice--limitation on specific medication or surgical procedures due to economic reasons rather than medical judgments.

***WMJ:* What do you believe to be the number one priority of organized medicine?**

FLAHERTY: Cost-effective delivery of quality health care. The issues that affect the AMA are the issues of society and reflect how society deals with problems. I see the AMA as a sounding board for many issues, and I believe the AMA can provide much expertise on the road to making society's decisions. But physicians by the nature of our training are not inclined to make rationing decisions concerning care for our patients.

It is ironic that physicians who make treatment breakthroughs in this country are held up as role models and society heroes. Yet tough decisions result from those very important breakthroughs; e.g. should the new technology be extended to all patients or just a few? I think it is the role of medicine to be involved in those tough decisions, but not to be the final arbitrator or dictator of public policy.

***WMJ:* What do you see to be the strengths and weaknesses of organized medicine? How could the federation of medicine be strengthened?**

FLAHERTY: Acting on the proposal of the Long-Range Planning Council, the AMA House of Delegates voted to fund a study to determine how all the various pieces of the federation would best fit together. The study is going to be very extensive and will take several years. But I think the study will be very worthwhile because there is a lot of duplication and replication of efforts among various medical organizations. Sometimes we are at cross swords, which is natural because there are issues we don't all agree on. But there are many efforts that are duplicated and replicated at the expense of dues-paying physicians. We need to see not only how we're interfacing but what we can do to make this a stronger organization.✦

Book review

Out of Dr Bill's Black Bag: From Northern Wisconsin a Country Doctor Looks Back

Russell King, editor

During the Dark Age of Greece, more than two centuries of political and social chaos, Homer created the *Odyssey*. In it, Classical Greece found an inspiration, a heroic model of what it means to be a moral human. During the 1st Century, BC, when the Romans were staggering from 100 years of avarice and war that finally brought the fall of the Republic, Vergil created the *Aeneid*. And in it, the Romans were given a mythic hero, an example of how life may best be lived.

Such examples, literary or otherwise, are in short supply in 1994. And what public heroes we create, we just as quickly destroy. Fortunately, the spirit of greatness slumbers in the hearts of most men and women, awakening and showing itself, however briefly, in life's most meaningful moments. And there are among us a precious few who quietly, unknowingly, privately exhibit that spirit in their daily lives. They carry no rank, earn no medals, lead no followers: They are simply common folk bringing an uncommon light to the darkness. They are our true heroes.

Out of Dr Bill's Black Bag is the story of such a hero. This is the autobiographical account of the 50-year medical career of William B.A.J. Bauer, MD. I know Dr Bill, so I know he will insist that in applying it to him, I am grossly misusing the word "hero." It won't be the first time he and I have disagreed, but it will be one of the few times he is wrong.

This charming book traces the evolution of a country doctor from childhood through "the first worrisome year as a solo physician," recounts the prime years of his medical practice in northern Wisconsin, and concludes with a healthful dose

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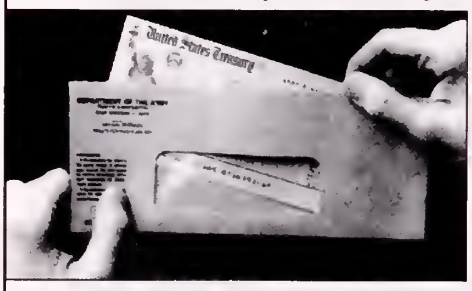

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of Dr Bill's unique brand of humble, homespun philosophy. The story really begins, however, in 1942, when he and his wife Gussie moved to Ladysmith. There, he treated--and grew to love and be loved by--the colorful cast of characters found in this book.

Over five decades, the quiet doctor became a legend: sage and poet, newspaper and magazine writer, civil leader and outstanding athlete, forester and ichthyologist, and author of *Brethren of the Brule*, Wisconsin's best book on the science and romance of trout.

Out of Dr Bill's Black Bag is a deceptive book in that the stories and characters are so engaging, so entertaining, so wildly funny, that we are tempted to take from it only those pleasures. Those alone would be worth the reading, but there is something more, something deeper. Just beneath the surface, never fully revealing itself, never even quite conscious of itself, lies the example of a life well lived.

Here is the commitment and the fear, the joy and the frustration, the dream and the doubt: Here is the full measure of a man and a physician. Here, among other tales, are a breech baby delivered in a one-room farmhouse in the middle of a snowy night, a showdown with a viciously cruel medical school professor, a profound strength drawn from a spiritual connection with the Earth, a night spent comforting a patient who was suffering a "heart attack" of grief over the loss of a loved one. Here are a wealth of lessons omitted from formal medical training but supplied by one physician's patients' births, deaths and all that is found between.

The distinguishing characteristic of Dr Bill's practice of life was also the hallmark of his practice of medicine, in that he used the same uncommon light to illuminate both. Just as he approached living as a passion, he approached medicine as a calling, not a career, and his compassion is his greatest legacy--to Ladysmith and to the physicians who follow him. With the publication of this unpretentious book, that legacy is recorded and preserved.

The last chapter of this moving story is yet to be written, for Dr Bill still stalks Wisconsin's north woods, still writes, still reaches out, still touches the lives of the people around him. But the last chapter of this book contains a letter Dr Bill received while recovering from cancer surgery in 1981. In that letter, we find a fitting tribute to a true hero:

It is important that you know that even now, in your difficult time, you continue to be our model of strength and compassion.

It is important that you know of our love.

We were the babies you delivered, the parents you advised, the elderly you comforted.

Your side of the bleachers is packed!

What would a modern Ulysses be like? I don't know, but my guess is that he or she would have a thing or two in common with one Dr Bill, of Ladysmith, Wis. *Out of Dr Bill's Black Bag: From Northern Wisconsin a Country Doctor Looks Back (1941-1991)*, a darn good book, is available for $19.95, plus $2.50 shipping and applicable state sales taxes, from: Brother Bill's Publishing Co., PO Box 9158, Rochester, MN 55903-9158.❖

SMS Board of Directors calls for withdrawal of Blue Cross lawsuit

THE SMS BOARD of Directors is calling for the withdrawal of a lawsuit filed by Blue Cross & Blue Shield of Wisconsin against the Marshfield Clinic on the grounds that such action is costly and a threat to the health of northern Wisconsin residents.

The lawsuit charges the Marshfield Clinic and its Security Health Plan HMO with attempting to monopolize health care and control prices in central and northern Wisconsin. SMS Executive Vice President Thomas L. Adams, CAE, said, "Tying up the state's largest clinic in court sends the clear message to smaller clinics that when Blue Cross and Blue Shield presents a proposal, there is no negotiating: You play by the Blue rules or you pay the price."

"The price of fighting and defending this case will be high, and that cost will be paid by the people who buy insurance and those who seek health care from the Marshfield system," Adams said in a statement released to statewide media. "In an era when we are all working together to curb unnecessary hikes in health care costs, a lawsuit is not the way to resolve problems. In effect, the suit would force the clinic to divest itself of its rural satellite clinics now serving many of Wisconsin's remote northern communities. If that happens the threat to access to health care in those already under-served areas will be critical. This lawsuit puts Blue Cross & Blue Shield's pursuit of business ahead of access to health care and is, quite simply, a danger to real people with real health care needs," Adams said.❖

SMS commission updates guidelines on terminal care in long-term care facilities and at home

THESE GUIDELINES were approved by the SMS Board of Directors March 25, 1987, and subsequently published in the *Wisconsin Medical Journal* (*Wis Med J*.1987;86(6):128-130). The guidelines have been widely distributed to physicians and nursing facilities in Wisconsin. Occasionally, requests are still received for copies.

The SMS Commission on Geriatric Health has been working since December 1992 to update these guidelines. One of the goals of the commission was to ensure that the guidelines would be viable in both home care and long-term care. The revisions have been reviewed and found acceptable by the SMS Commission on Medicine and Ethics, the Bureau of Quality Compliance, Robyn Shapiro, JD, director of the Center for the Study of Bioethics, members of the Wisconsin Association of Medical Directors, and SMS legal staff.

This statement is not intended to serve as a standard of medical care. Standards of medical care are established on the basis of the facts of individual cases and are constantly subject to change.

Contemporary American society offers a wide range of philosophies regarding death and dying, none of which is necessarily intrinsically better than another. An increasing number of people are signing living wills or otherwise indicating a preference for "death with dignity," or at least a terminal course not involving extensive medical intervention. Medical science continues to make dramatic progress. New diagnostic and therapeutic modalities continue to become available, and health care providers, as well as many patients and their families, continue to request the most modern and complete care. Limited treatment policies, however, are now becoming common in long-term care facilities and at home.

Although the social commitment of the physician is to prolong life and relieve suffering, the AMA states that where the observance of one conflicts with the other, the choice of the patient should prevail. If the patients are incapacitated and did not previously indicate their preferences, the patients' surrogate decision-makers, in concert with the physician, must act in the patients' best interests.[1,2]

Making decisions

Because the care of residents in long-term care facilities and at home often involves many individuals--including the family, clergy, nursing staff, social services staff, and others--the physician, who will usually "captain" the medical teams, must be sure that the patients' needs are

SMS Board restructures Commission on Safe Transportation

THE SMS BOARD of Directors voted Feb 26 to accept the Executive Committee's recommendation to restructure the Commission on Safe Transportation into a new commission titled as the "Commission on Injury Prevention and Control and Emergency Medical Services."

Enacted in 1955, the SMS Commission on Safe Transportation has been influential over the years in shaping public policy on many different issues, notably: implied consent laws, drunk driving enforcement, seat belt regulations, medical standards for school bus drivers, licensure for older drivers, vision standards, infant seat restraints, and headlight safety. Transportation injuries have been steadily declining. Over the past year, the Commission on Safe Transportation, chaired by Stephen Hargarten, MD, has discussed restructing into a new commission to discuss a broader range of topics.

The charge of the newly created commission is as follows: "The commission shall be concerned with the prevention and control of accidental and intentional injuries. It shall examine and recommend public safety measures for reducing the incidence of untimely injury or death resulting from, but not limited to, gun violence, domestic abuse, transportation accidents, fires, drownings and falls. The commission shall also examine and recommend measures for assuring effective emergency medical systems in Wisconsin."

Physicians who are interested in serving on the new commission may contact Don Lord at the SMS, (800) 362-9080 or (608) 257-6781, or Dr Raymond Zastrow, vice chair of the Board of Directors, at (414) 527-8404. The chair and commission appointments will be made at the annual meeting in April.❖

met and that the medical care delivered meets the ethical standards of the medical profession.

If the patients are capable of making treatment decisions, their wishes should be represented and documented in the medical record. If the patients are incapacitated and have signed living wills or health care powers of attorney, these treatment directions should be honored, and the patients' surrogates should be consulted. This consultation should be documented in the patients' medical records. (For purposes of these guidelines, the term "surrogate" means: guardian, health care agent, if there is no guardian; or spouse, adult children, parents, adult siblings, other adult relatives and close friends, if there is no guardian or health care agent.) In order of priority, a best interest decision should:

- reflect the patients' specific wishes previously and clearly stated (written or oral);
- reflect the patients' probable wishes as best judged by the proxy decision makers based on the patients' previous statements, actions, or lifestyles, or the patients' values or religious or philosophical beliefs; and
- follow that course based on such factors as the life expectancy and prognosis with and without treatment; the risks, side-effects, and benefits of the treatment options; the degree of dependence and loss of dignity from the condition and treatment; and the opinion of the bioethics committee (when one has been consulted).

In cases of disagreement regarding the course of care, consultation from an ethics committee may be helpful.

Types of decisions

A variety of decisions involving ethical issues may be faced in long-term care. For example, whether ongoing care is to be provided in the hospital or the patient is to continue in the long-term care facility or at home. The decision to be hospitalized may apply only to some illnesses and not to others. If a patient decides to remain in the long-term care facility or at home and faces a likely down-hill course, a plan of care should be constructed in accordance with the guidelines discussed above in the previous section.

Cardiopulmonary resuscitation (CPR) also poses the need for advance planning. It is consistent with sound medical practice not to attempt CPR in certain situations, such as cases where CPR does not represent the patient's wishes or where it most likely will be futile.

In all societies, provision of food and water is perceived as a critical part of human nurturing and caring for one another, as well as a physical necessity of life. Decisions regarding the provision of nutrition and hydration should be made in this context.[4] Nevertheless, when natural nutrition and hydration cannot be safely accomplished by self-administration or with manual assistance of others, medically administered nutrition and hydration (via tubes) may be withheld if the patient so directs (or has previously expressed such a preference) or such withholding would be in the patient's best interests.

Documenting the plan

Because the options are so broad, the plan of medical care for each patient should be individually constructed. Thus, when patients in long-term care facilities or at home deteriorate, their plans of care should be revised to reflect the change of condition. The patients' plans of care needs to be converted into physician orders. Such generalizations as "comfort measures" or "hold meds" should be avoided: a positive, orderly, and complete set of medical

Continued on next page

SMS meeting planner earns certification

Kristin Krueger, SMS managing director of meeting services and medical education, has achieved the status of "certified meeting professional" through academic examination and professional experience. The CMP designation is conferred by the national Convention Liaison Council, and currently there are only 1,540 certified meeting professionals worldwide.❖

Health system reform session set for SMS annual meeting

A SPECIAL PRESENTATION in health system reform has been scheduled for 9 am Friday, April 15, during the final session of the SMS House of Delegates. Kermit Newcomer, MD, chair of the SMS Commission on Health Care Financing and Delivery, will moderate the session. Presenters include: Thomas Barrett, D-5th Congressional District, Milwaukee; Scott Klug, R-2nd Congressional District, Madison; and Donald T. Lewers, MD, AMA trustee, Easton, Md.❖

Continued from preceding page
orders should be written.

The patients' diagnoses, prognoses, and the treatment preferences as expressed by the patients, or as related by families or surrogates with specific mention of their names, should be clearly documented at the time of admission, or as soon as appropriate, and readily accessible. Federal law requires long-term care facilities and home health care agencies to inquire about the existence of an advance directive at the time of a patient's admission, provide information about state laws on advance directives, notify the patient of the facility's policy on the use of advance directives, and to include advance directives in the patient's medical records.[5] Long-term care facilities and home health care agencies, however, legally may not require an individual to execute an advanced directive.

Dietary orders concerning the patients' nutritional status should be written so that modification can be made as their appetites and abilities to handle food changes. The patients' activity levels should be reviewed and activity orders adapted to their capabilities. The patients' activity, medications, and treatments should be reviewed as their conditions change. Those medications that continue to be necessary and appropriate should be continued. Others should be eliminated. The dosage and mode of administration of medication and the circumstances of treatment may need modification to ensure that the patients will be able to tolerate or retain them. Care should be taken to give the patients the maximum comfort possible, while keeping in mind the necessity of not over-medicating the patients with advanced illness and age.

In summary, the patients' medical records must contain the results of the planning process and the concurrence of the various parties involved by name. Conferences sharing prognosis, problems, and plans held at intervals may resolve conflicts, avoid misunderstandings, and assure common goals and inclusion of all parties in patient care.

Comforting patients

Planning the patients' care with the patients or their surrogates; discussing the care plans with involved parties; documenting the plans of care by writing the appropriate orders; ensuring the plans' implementation; and making appropriate adjustments in the care plans with the patients or their surrogates, are the major responsibilities of the physician. A positive attitude with concern for the comfort, anxiety, and dignity of the dying patients, and the difficulty of the staff and the families, is the goal of terminal care.

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Physician briefs

The * indicates an SMS member.

Mahmoud Ahmed, MD,* and **Charles Van Der Heide, MD,*** have joined the staff of Midelfort Clinic in Eau Claire. Dr Ahmed, a psychiatrist affiliated with the Center for Pain and Stress Management at Luther Hospital, received his medical degree from the University of Cairo, Egypt, and performed his residency at the Winnebago Health Institute in Oshkosh. Dr Van Derr Heide received his medical degree from Northwestern University in Chicago. His residency in adult psychiatry was performed at the University of Cincinnati and he completed a fellowship in child psychiatry at Yale Child Study Center in New Haven, Conn. Dr Van Der Heide is board certified in adult, adolescent and child psychiatry.

Kathryn Balough, MD,* a Physicians Plus Medical Group pediatric allergist, has joined the staff at the Monroe Clinic. She received her medical degree at the University of Illinois College of Medicine in Chicago. She completed her pediatric residency at William Beaumont Hospital in Royal Oak, Mich, a pediatric allergy fellowship at the University of Iowa Hospitals and Clinic. Dr Balough is board certified in pediatrics and board eligible in allergy and immunology.

Robert A. Cavanaugh, MD,* has been named president of Bellin Hospital's medical staff. The obstetrician/gynecologist will serve a 2-year term.

Abigail Christensen, MD, and **Kathy Kowalke, MD,*** have joined

Continued on page 142

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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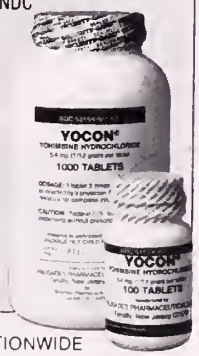

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Continued from page 140
the staff of the Dean Medical Clinic in Madison. Dr Christensen is a gastroenterologist. Dr Kowalke is a psychiatrist.

Edsel G. Doreza, MD,* has been appointed to the clinical faculty of the University of Wisconsin College of Medicine as a clinical assistant professor in medicine and nephrology. Dr Doreza serves as medial director of Beloit Hospital's dialysis program under the association of the University of Wisconsin hospitals.

William T. Franks, MD, has joined the Montello Family Medical Practice Clinic. Dr Franks is a board-certified family practice physician and a graduate of the University of Indiana School of Medicine. He completed a 3-year family practice residency at Ball Memorial Hospital in Muncie.

Elliot G. Goldin, MD, of Berlin Surgical Associates recently received a 3-year appointment as cancer liaison physician as part of the Commission on Cancer of the American College of Surgeons. Dr Goldin is among a national network of more than 2,000 volunteer cancer liaisons who provide leadership and support to a hospital tumor registrar and encourages medical staff to use data generated by the registry.

Doug Kramer, MD,* has joined the Physicians Plus Medical Group in Madison. Dr Kramer is a board-certified psychiatrist.

Richard Leer, MD,* a family practice physician, has been re-elected to a fourth term as president of Marshfield Clinic. Dr Leer has served on the clinic's executive committee since 1985. He joined the medical staff in 1977.

Al Mendoza, MD,* a pediatrician, has joined the Riverview Clinic of Dean Medical Center. Dr Mendoza completed an internship and residency in pediatrics at the Children's Hospital of Wisconsin in 1992. Before joining Riverview Clinic, he was on staff at the Burlington Clinic.

Karen B. Mielke, MD, is a new addition to the Marshfield Clinic staff. Dr Mielke earned her medial degree from the University of Minnesota Medical School in Minneapolis. She served her residency in pediatrics at Mayo Graduate School of Medicine in Rochester.

Angela Miller, MD,* has joined the staff at the Monroe Clinic of New Glarus. Dr Miller received her medical degree from Loyola University in Maywood, Ill. She completed her internship and residency at the University of Illinois, Department of Pediatrics, in Chicago. She is board certified in pediatrics.

David Ulery, MD,* of Waukesha, was recently board certified in sports medicine, making him only one of 15 US physicians certified in both pediatrics and sports medicine. Dr Ulery is a pediatrician at Wilkinson Medical Clinic.

County society news

Dane. The following members have been received by the Dane County Medical Society: Abigail Christiansen, MD; Thomas Ferrella, MD; Michael Goldstein, MD; Mohammad Razzaq, MD; Alessandro Rossi, MD; and Mustafa Sahin, MD.

Eau Claire, Dunn, Pepin. The following physicians were elected to membership in the Eau Claire, Dunn, Pepin Counties Medical Society Jan 24, 1994: Abolghasem D. Javaherian, MD; Wolfram G. Schynoll, MD; and Charles J. Van Der Heide, MD.

Fond du Lac. Jean Lyke, MD, has been elected to membership in the Fond du Lac County Medical Society.

LaCrosse. The following physicians were elected to membership in the La Crosse County Medical Society: Michael Brent Porter, MD; Safir U. Shaheen, MD; and Susan S. Quinn, MD.

Langlade. The Langlade County Medical Society approved membership for Curtis M. Bejes, MD; and Michael R. Probstfeld, MD.

Marathon. The Marathon County Medical Society approved membership for Mark Neil Weissman, MD; Juan Fernandez III, MD; and Thomas A. Koepke, MD.

Price. The Price County Medical Society approved membership for Kurt Brown, DO.

Racine. James C. Cadwallader, MD, has been approved for membership in the Racine County Medical Society.

Richland. The Richland County Medical Society approved membership for Edward Abbott, MD.

Rock. The Rock County Medical Society approved membership for Sonya Naryshkin, MD.

Sauk. Membership in the Sauk County Medical Society has been approved for Douglas Atkins, MD.

Waukesha. The Waukesha County Medical Society approved membership for Mark A. Meier, MD; Waheed Bajwa, MD; Robert Burney, MD; and Scott Linton, MD.❖

Jackie L. Yaeger, MD,* has joined the Whitewater Family Practice Clinic. Dr Yaeger earned an undergraduate degree in biology at St Olaf College in Northfield, Minn. She received her medical degree at the University of Iowa College of Medicine and completed residency training at the University of Wisconsin Family Practice Residency Program in Wausau.

John R. Zandt, MD*, has joined the Waukesha Medical Centers-East Broadway. Dr Zandt is a 1988 graduate of the University of Wisconsin Medical School. He completed his residency in 1991 at Bayside Medical Center in Springfield, Mass, and is board certified in internal medicine.❖

WIPRO investigated

THE WISCONSIN Peer Review Organization (WIPRO), Medicare's utilization and quality control peer review organization for Wisconsin is undergoing an investigation by the Office of the Inspector General (OIG) of the Department of Health and Human Services. The OIG investigates federal contractors to assure that federal funds are being expended in a manner consistent with existing contracts. WIPRO is confident that this investigation will turn up no irregularities and that WIPRO is in compliance with federal guidelines. WIPRO maintains an open policy of fully cooperating with the federal government in all of the government's efforts to maintain high quality health care for Medicare and Medicaid recipients in Wisconsin. Questions may be directed to Bill White at 283-2246.❖

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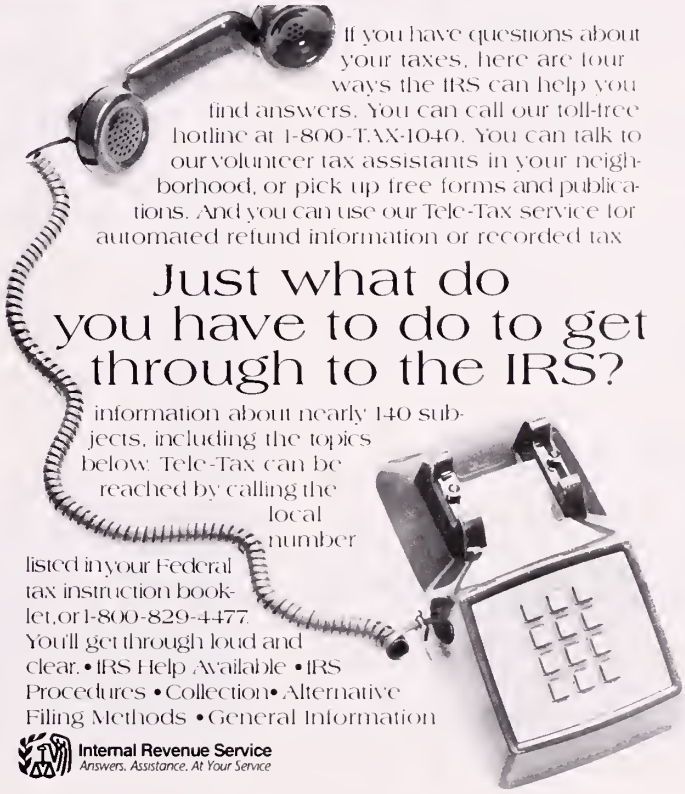

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information about nearly 140 subjects, including the topics below. Tele-Tax can be reached by calling the local number listed in your Federal tax instruction booklet, or 1-800-829-4477. You'll get through loud and clear. • IRS Help Available • IRS Procedures • Collection • Alternative Filing Methods • General Information

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The individuals named below made contributions to the Charitable, Educational and Scientific Foundation through the SMS membership

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Obituaries

Benjamin, Hiram B., MD, died Dec 16, 1993. Dr Benjamin received his medical degree at Marquette University in 1930, and served his internship and residency at Milwaukee County Hospital. He was a fellow of the International College of Angiology, a fellow of the International College of Surgeons, Professor Emeritus of the Medical College of Wisconsin and the former Marquette University Medical School. Dr Benjamin was a member of the SMS and the Medical Society of Milwaukee County. He is survived by his wife, Helen; three stepchildren, Chris Potos, Andrew Potos, and Dr William Potos; seven grandchildren and four great-grandchildren.

Brah, William A., MD, died Jan 29, 1994, in Mequon. Dr Brah was a surgeon for 31 years. He graduated from Marquette Medical School in

Milwaukee. He completed his internship and residency at St Joseph's Hospital in Milwaukee. He was a member of the SMS, Medical Society of Milwaukee County, American Medical Association, Wisconsin Surgical Society, American College of Surgeons, and the Milwaukee Gastroenterological Society. Dr Brah is survived by his wife, Marguerite; a son, William, and a daughter, Christine Curro; five grandchildren; and a sister.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

Culver, John R., MD, Died Jan 3, 1994, in Oconto Falls. He received his medical degree from the George Washington University in Washington, DC. He served his internship at St Joseph's Hospital in Flint, Mich, and completed his residency in Williamson, WVa. He moved to Oconto Falls in 1957, where he established a private practice which he continued until the time of his death. Dr Culver was a member of the National Medical Honor Society, Alpha Omega Alpha, Smith Reed Russell Honor Society, the Kane-Kine Obstetric Society, Nu Sigma Nu and vice president of the William Beaumont Honor Society. He was a member of the SMS and past president of the Oconto County Medical Society. Dr Culver is survived by his wife, Miriam; one daughter, Marsha Page of Iron Mountain, Mich; two sons, John of Lincolnwood, Ill, and Paul of Milwaukee; five grandchildren; one brother and one sister.

Dorr, Robert H., MD, died Jan 10, 1994, in Cedarburg. He earned his medical degree at Marquette Medical School. Following a year of practice in Milwaukee, he entered the U.S. public health service. He was stationed at various posts in the United States and throughout Mexico. In 1946, Dr Dorr established his practice in Belgium, where he served until his retirement in 1979. Dr Dorr was a member of the SMS and the Ozaukee County Medical Society. He is survived by his wife, Jane, and three sons, John and Joseph of Cedarburg, and James of Milwaukee.

Fruehauf, Richard P., MD, died Jan 26, 1994. He graduated from the University of Illinois in 1941, and interned at Milwaukee County Hospital. He practiced medicine in Superior from 1942 to 1989. Dr Fruehauf was the staff physician for the University of Wisconsin-Superior from 1957 to 1986, and was chief of staff at the former St Francis, St Mary's and St Joseph's hospitals in Superior. He was a member of the SMS, the Douglas County Medical Society, and the AMA. He received an award for 50 years of service from the SMS in 1991. Dr Fruehauf is survived by his wife, Evelyn; four daughters, Patricia Dalum, of Marshfield, Mary Fruehauf, of Milwaukee, Jean Patrenets, of Wisconsin Dells, and Catherine Pokorny, of Burnsville, Minn; one son, Richard, Jr., of Superior; and six grandchildren.

Hirschboeck, John S., MD, died Jan 28, 1994, in Milwaukee. Dr Hirschboeck graduated from Marquette University School of Medicine and served his internship and residency at Milwaukee County Hospital. During World War II he held the rank of lieutenant commander in the US Navy Medical Corps. Following the war in 1945, he engaged in private practice in Milwaukee until he was named dean of the School of Medicine at Marquette in 1947. In 1963, he was named to the new office of vice president and secretary of the board of directors of the Marquette School of Medicine. He was a member of the SMS, Medical Society of Milwaukee County, board of directors of the National Intern Matching Program, a fellow of the American College of Physicians, a diplomate of the American Board of internal Medicine, and past vice president of the National Society for Medical Research.

Lennon, Edward J., MD, died Jan 11, 1994, at the age of 66. He received his medical degree from Northwestern University School of Medicine, Chicago. He served his internship and residency at Milwaukee County General Hospital. Dr Lennon was named president of the Medical College of Wisconsin in 1984. He was the chief of the renal section at the Medical College of Wisconsin's Department of Medicine from 1960 to 1970, program director of the college's Clinical Research Center from 1961 to 1969, associate dean for clinical affairs from 1968 to 1978, and dean of the Medical College and academic vice president from 1978 to 1984. Dr Lennon was a member of the SMS and the Medical Society of Milwaukee County. He is survived

by his wife, Janice; a daughter, Mary Louise Bennett of Penn; two sons, Robert and Kevin; and four grandchildren.

Nimz, Robert A., MD, died Jan 22, 1994, in Milwaukee. He was a physician for more than 40 years in Milwaukee and former chief of staff at St Michael Hospital. Dr Nimz received his medical degree from Marquette University in 1936 and did his residency at Milwaukee County General Hospital. He was a staff physician for the Wisconsin Electric Power Company. Survivors include a son, Robert, of Milwaukee, and two daughters, Carol Dahlke, of Wauwatosa and Alice Jane Berg, of Elm Grove.

Steffen, Elizabeth Allen, MD, died Dec 13, 1993. She received her medical degree from McGill University School of Medicine-Montreal, Canada, in 1945, interned at Swedish Covenant Hospital, Chicago, and completed her residency at Women's Medical College, Philadelphia, Penn. Dr Steffen served as president of the Racine County Medical Society in 1969, as well as chief of staff of St Luke's Hospital from 1976 to 1977. She was chief of obstetrics and gynecology at St Mary's Medical Center from 1988 until 1990, and president of the Wisconsin Obstetrician and Gynecological Society in 1970. She was also a clinical professor with the Medical College of Wisconsin and a diplomat of the American College of Obstetricians and Gynecologists. She was a fellow of the American College of Surgeons and the International College of Surgeons. Following her retirement, Dr Steffen opened a clinic to the Health Care Network, offering medical care to individuals without health insurance. She is survived by her sister and brother-in-law, Jean and Clarence Smith of Evanston, Ill, and a nephew.

Stoerker, Ruth A., MD, died Jan 11, 1994. She received her medical degree from the University of Michigan and took a rotating internship at the Indiana University Medical Center in Indianapolis. She served a residency in anesthesia at the University of Wisconsin Medical School. She was on the UW anesthesia faculty from 1956 to 1975 and was a staff anesthesiologist at the William S. Middleton Memorial Veterans Hospital from 1975 until her retirement in 1993. She was a member of the Wisconsin Society of Anesthesiologists, serving as secretary and president, and was a delegate to the national organization. She was also a member of the SMS and the Dane County Medical Society. Dr Stoerker is survived by her husband, Arthur Tiedemann; two children, JoAnn, of Tomahawk, and Norman of Bolingbrook, Illinois; a brother and a sister.

Taborsky, Charles R., MD, died Feb 19, 1994. He was born on Feb 5, 1920,

Continued on next page

AMA awards

THE WISCONSIN physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

January 1994

* Anderson, Charles J.
* Bowler, William A.
* Boxer, Richard J.
* Brown, Ward M.
* Carlson, Alan R.
Chang, Chen-Kang
Cusick, Joseph F.
* Davidoff, Donna D.
* Dibbell, David G.
* Dudek, Stephen L.
* Goell, William S.
* Gueldner, Terry L.
* Jefferson, James W.
* Karen, Robert
Lawton, Colleen A.
* Mann, Dale H.
* Mateo, Raul
* Matzke, Robert F.
* McDonald, Donald H.
* Pechman, Kenneth J.
* Roberts, Richard G.
Sherry, James J.
Walsh, Patrick R.
* Wild, Joseph P.❖

Physician impairment program offered

THE SMS STATEWIDE Physician Health Program and Wisconsin Hospital Association are cosponsoring a program titled "Healing the healers: an update on physician impairment." The program will be held May 6, 1994, from 9 AM to 12:30 PM, at the Milwaukee Psychiatric Hospital Arthur Norris, MD, Memorial Auditorium, in Wauwatosa.

The program qualifies for 3.5 credit hours in Category 1 of the AMA Physician Recognition Award and is approved for 3.25 credit hours by the ACMPE.

There is a $35 registration fee to cover program expenses; the remainder will be transmitted to the Benevolent Assistance Fund of the SMS CES Foundation.

For further information, contact Sonia Porter or John LaBissoniere at PO Box 1109, Madison, WI 53701; (608) 257-6781 or (outside of Madison area) 1-800-362-9080.❖

Continued from preceding page
and graduated from the University of Wisconsin Medical School in 1943. Dr Taborsky completed his internship at Orange Memorial Hospital in New Jersey, and his residency in otolaryngology at the University of Wisconsin. He served in the US Army Medical Corps from 1945 to 1947. He practiced the specialty of otolaryngology in Madison from 1945, until his retirement in 1984. Dr Taborsky was a Diplomate of the American Board of Otolaryngology and a member of the American Academy of Otolaryngology and Head and Neck Surgery, American College of Surgeons, AMA, Dane County Medical Society, and SMS. He was president of the Wisconsin Society of Otolaryngology, chief of otolaryngology and associate professor of surgery at the University of Wisconsin Medical School, and following retirement, he was on the honorary staff of Madison General Hospital. He is survived by his wife, Nancy; two sons, Tom and Peter of Madison; two daughters, Mary Varda of Madison and Katherine of McFarland; two granddaughters; and a sister.

Tonkens, Samuel W., MD, died Jan 14, 1994. He was the former chief of dermatology at the Zablocki Veterans Affairs Medical Center from 1971 to 1979, and a former clinical professor of dermatology at the Medical College of Wisconsin. Dr Tonkens received his medical degree from the University of Chicago School of Medicine in 1936. He began his career in dermatology with 2 years at the University of Illinois and one year at the internationally known St John's Hospital for Skin Disease in London. He returned to Milwaukee, and after 3 years of private practice, joined the VA staff. Survivors include a brother, Salvin Tonkens of Leawood, Kan, and nieces and nephews.❖

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OSHKOSH, WISCONSIN - Medical groups are recruiting in Family Practice, OB/GYN, Internal Medicine, Emergency Medicine, Pulmonology, and Orthopedic Surgery. Mercy Medical Center has an active medical staff of 150 physicians in all medical specialties. Oshkosh is an attractive community of 55,000 people, located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley (metro area of 350,000 people). University of 12,000 students. Good local schools. Low crime area. Contact: Christopher Kashnig, Mercy Medical Center, 631 Hazel Street, Oshkosh, WI 54902. Call 414-236-2430. Fax 414-236-1312. 3-4/94

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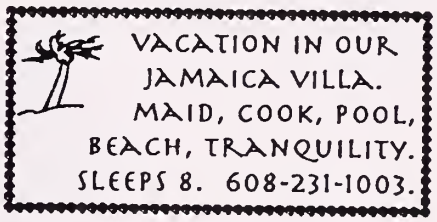

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"Leflunomide: A New Direction in Immunosuppression" will be the topic of the Fifth Annual Rush Symposium on Transplantation. The symposium will be at Rush-Presbyterian-St. Luke's Medical Center in Chicago on Saturday, May 21, 1994, at 9:00 a.m. The rapidly advancing technology in anti-rejection therapy has led to a new and promising direction in immunosuppressive drugs, specifically the novel drug Leflunomide. Leflunomide has many promising properties including its ability to prevent and reverse allograft rejection, to down-regulate alloantibody production and to provide exceptional control of concordant xeno rejection, placing it high among the small group of evolving drugs with potential for clinical transplantation. A series of lectures describing its action in rodents and in dogs in various transplant models, its mechanism of action and the early expanse in human use will be presented in this day long symposium. To register for the symposium or for more information, please call the Transplant Program Physician Relations Coordinator at 312-942-6242. 3-4/94

AMA

June 12-16, 1994: Annual AMA House of Delegates, Chicago.

December 4-7, 1994: Interim House of Delegates, Honolulu.

Announcement

International Symposium on Electrical Management of Cardiac Arrhythmias 1994. June 29-July 1, 1994. Indianapolis, Indiana. Fees: $455 for ACC members; $520 for non-members; $310 for fellows-in-training, residents, nurses, physician assistants, and technologists. 21 Category 1 credit hours. For information, call American College of Cardiology 1-800-257-4739, FAX 1-301-897-9745.

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State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS - 1994-1995

The 1994 meeting will be in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the Hyatt Regency as the headquarters hotel.

1994 - April 13-16: Milwaukee

1995 - April 5-8: Milwaukee

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free: 1-800-362-9080.

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BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association.*

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Contents

April 1994 Vol. 93 No. 4

Opinions

155 *President's page*
We face the challenges together
by Pauline M. Jackson, MD, La Crosse

156 *EVP report: The view from here*
This is no time to turn and run
by Thomas L. Adams, CAE, Madison

Scientific

159 The Health Information Technology Center at the Medical College of Wisconsin
by William R. Hendee, PhD; Mary Anne Urlakis, BS; and Mary Blackwelder, MLS, Milwaukee

165 A profile of geriatric trauma in southeastern Wisconsin
by Verena T. Valley, MD; Holly Hepp, RN; Daniel J. DeBehnke, MD; Sarah W. Lawrence, RN; and Charles Aprahamian, MD, Milwaukee

169 Incarcerated hernia with intestinal obstruction after laparoscopic cholecystectomy
by Marvin Wagner, MD, and George E. Farley, MD, Milwaukee

Socioeconomic

173 *Public health*
Self-reported cardiovascular risk factors among diabetics and non-diabetics in Wisconsin
by Patrick L. Remington, MD, MPH, and Nancy E. Chudy, MPH, Madison

Organizational

177 Wisconsin delegation joins unity demonstration on health system reform
178 SMS Board of Directors approves policy on reporting of domestic violence
178 The assessment and treatment of victims of domestic abuse: model protocol
183 Dr Roberts meets "smoke-free kids" at state Capitol
185 Physician briefs
186 Obituaries
188 A call for papers

Our cover: Our cover story begins on page 159. Photo by Comstock Photo of New York.

Wisconsin Medical Journal

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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President's page

We face the challenges together

HAVING ARRIVED at the end of my year as SMS president, I reflect on the efforts at health system reform and how we can continue to improve patient care in the future, two concepts which must continue to work in concert.

SMS leaders and staff have been active participants in the reform discussions here in Wisconsin and in Washington. Having *Wisconsin Care* as our vehicle to express physicians' wishes was extremely helpful. The eight elements for health system reform reaffirmed by the Board of Directors throughout the year gave us a consistent platform.

Our state legislators have been unable to agree on any changes, but the intense amount of work they put into the process is sure to lead to continuing efforts. In Washington, a compromise plan barely passed in the House Ways and Means health subcommittee. As Rep Pete Stark said, "It's the first step in a long journey." So many plans to compare, so much political rhetoric to dissect. An SMS commission to work on our 1994-1995 health plan, updating *Wisconsin Care*, will keep our opinions active in this process.

Meanwhile, the focus of physician and patient concerns is ever changing. There is no doubt but that it is in everybody's interest for people to stay as healthy as possible. In other countries where national health plans have been instituted (none of which has proven to be a model for the United States to follow), people are "statistically sicker." According to a report from the National Center for Policy Analysis, they take more sick leave from their jobs; they make more visits to their doctors--12.9 per year in Japan and 11.5 in Germany compared with 5.5 visits in the United States; and they have more hospital days, which average 6.5 days in the United States are 11.4 in Canada and 44.9 in Japan.

Pauline Jackson, MD

There are, of course, many reasons for this--often due to the bureaucratic process itself--but there is the nagging thought that being sick under some government health plans might be more generally acceptable than our own tradition teaches.

Whatever health system reform ultimately looks like, we in the United States must take this opportunity to

Continued on next page

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board. Write to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.❖

Continued from previous page
improve preventive strategies and promote primary responsibility by individuals for their own good health. The latter is a new concept for many people who have grown up with the entitlement philosophy. Most people, however, are trying to learn how to take better care of themselves, and they appreciate our increased focus on patient education. In any viable health plan there will have to be incentives for pursuing good health and not using medical resources unnecessarily. As physicians, we can offer much through individual patient contact and community involvement.

In addition, we are no longer avoiding those previously designated social problems that cause so much sickness and concomitant cost increases. The areas of domestic abuse, tobacco-caused illness, injuries and violent crime are part of our prevention role as physicians and will be ever more imperative in the next few years. Each physician must be in some ways a public health officer. Acknowledging these needs, the SMS Commission on Safe Transportation has asked that its charge be revised and its name changed to the Commission on Injury Prevention and Control. The name is a bit awesome, but so is the task.

Extending this concept to all SMS activities, we will meet the changes we face as physicians being catapulted into the next century. It is a challenging time that calls for our alert attention and participation. I am privileged to be, with you, a part of the process.❖

EVP report: The view from here
This is no time to turn and run

In August 1976, I was serving as chief of staff to US Congressman Lamar Gudger (D-NC) in Washington, DC. Washington in August is a very different place from what it is any other time of the year. Both politicians and bureaucrats leave what becomes a very humid, oppressively hot city for cooler climates and vacation spots. That summer, I stayed behind in Washington to catch up on work and interview candidates for some staff vacancies.

When the members are out of town, staff are free to use the members' private dining rooms in the Capitol. One day, I went to the Capitol and, finding the House members' dining room closed, made my way to the Senate side of the Capitol to use the senators' facility. While waiting for a table, I noticed Sen Hubert Humphrey sitting alone and waiting to order lunch.

The senator, who was dying of cancer at the time, noticed that I was also alone and asked, "Young man, would you like to have lunch with me?" Needless to say, I accepted and was then fortunate enough to spend an hour or so listening to one of the greatest men of the last generation talk of his hope for the future of the nation.

It was an experience I will never forget.

Here was a man who had been vice president of the United States, a framer of the Great Society programs of the Johnson administration, and he was willing to spend his time trying to shape the thoughts of the next generation. Regardless of what we may have thought about his political ideas, there is no question that Humphrey was a man of power and influence during his time, as well as a man of great compassion and humility. He was also a man who insisted on meeting problems head-on and who preferred to be thorough in dealing with them.

(Sometimes the senator could be a bit too earnest in addressing a problem. After one of his longer speeches, Muriel Humphrey whispered to her husband, "Hubert, you don't have to be eternal to be immortal.")

I wonder now what the senator would think of the current timid approach to reforming our nation's health care system. My guess is that he would find our efforts wanting. My guess is that he would gently, firmly, persuasively tell insurers, physicians, hospitals, business lead-

Thomas L. Adams, CAE

Continued on page 158

The Hospital Medical Staff Section
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Interactive Dialogue with AMA Board of Trustees

HMSS representatives will not want to miss this year's AMA-HMSS Annual Assembly Meeting held on **June 9-13** in Chicago. Aside from the usual policy-related activities, representatives will have an opportunity to dialogue with the AMA Board of Trustees, hear the latest news and information from Washington, and learn the importance of and methods for physician involvement in health system reform.

The Friday education program hosts an impressive panel of speakers. From their remarks, representatives will learn: the impact of proposed legislation on the future practice of medicine; the kinds of managed care entities most likely to thrive; the ways to cope with health care delivery changes at the local level; the support needed to pass legislation on physician involvement in health system reform; the steps for developing a physician-directed health delivery network or plan; and the best methods for managing patient care and physician compensation in physician health plans.

Physician Involvement in Health System Reform

With health system reform legislation pending before Congress, state health system reform initiatives, and the rapid development of integrated delivery systems, it is vitally important that medical staffs mobilize to stand up and speak out for patients and the profession. The June Assembly meeting is no exception. Now perhaps more than ever before, HMSS representatives need to be involved in shaping the nation's future health care system.

HMSS past actions have made a difference. The AMA has incorporated many issues advocated by HMSS in its new health system reform proposal for action and model legislation. Basically, the draft bill:

- requires that health plans establish a medical staff structure with defined rights with regard to the plan's medical policy, utilization, quality and credentialing and management issues;
- expressly permits physicians to jointly present their views on any plan issue (without boycott or strikes) to plan management for discussion and negotiation;
- directly aids physicians in the creation of their own plans or networks to compete with large insurance companies;
- requires negotiation of new regulations with the profession before their announcement ; and
- expands the role and protection for the profession's accreditation, standard setting and medical society disciplinary functions.

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American Medical Association

Physicians dedicated to the health of America

Continued from page 156
ers and captains of industry to buck up and work together, to put aside their "special" interests, to find a solution.

Unfortunately, I am increasingly pessimistic about what sorts of changes will occur. The failure of the Congress to reach consensus, the media's fascination with Whitewater, and the demands on the president to respond to public perceptions that other problems, such as crime, are more pressing may all serve to prevent us from doing more than scratching the surface this year. There are some in Washington who, upon seeing that health system reform will require a great deal of work (and create some political risk), prefer to close their eyes and proclaim that there is no need for reform--that there are no weaknesses in the current system.

Essentially, some of the people Americans elected to lead the country kick into full retreat the moment they encountered their first tough battle. Whether that gets them off the hook remains to be seen, but denying reality doesn't make it go away and health professionals and their patients will still be on the battlefield long after their "leaders" have fled the scene.

What we are left with is a great opportunity brilliantly disguised as a series of insoluble problems. And just as it was left to physicians to first identify the flaws in the current health delivery system, it now seems left to physicians to revive the drive for reform. Your medical society is pressing on, taking measure of where we are, and laying plans for how best to proceed when the state legislature reconvenes (barring any unexpected special sessions) next January. If politicians want to hold positions of leadership, they must be prepared to provide real leadership, and your state medical society will act as a reminder, keeping the heat on. Like August in DC, we plan to make them sweat.❖

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The Health Information Technology Center at the Medical College of Wisconsin

William R. Hendee, PhD; Mary Anne Urlakis, BS; and Mary Blackwelder, MLS, Milwaukee

Everyone working in health care today is overwhelmed by scientific and medical information. Effective use of this information requires access to sophisticated information communications technologies. At the Medical College of Wisconsin, the Health Information Technology Center provides these technologies for biomedical research, medical education, clinical service, and health policy analysis. Several of the center's services are available to community health care providers through the college's Medical Information Network.*Wis Med J*.1994;93(4)159-163.

EVERYONE WORKING in health care today is overwhelmed by information important to his or her work. Most of us spend some time each day trying to stay abreast of events in science and medicine. Yet, a physician who reads two scientific papers each day would fall more than 60 centuries behind after just one year.[1] To cover everything of potential importance, about 6,000 articles per day would have to be read. Each year, 8 million to 10 million scientific and technical documents are published, including 2 million biomedical papers, 75,000 books and 300,000 patents.[2]

More new scientific information has been compiled in the past 30 years than in the preceding 5,000. Since 1750, when about 10 scientific journals were published, the number of journals has increased tenfold every 50 years.[2] Today, about 100,000 scientific journals are being published, of which about 25,000 are biomedical.[3]

Articles and books proliferate in part because scientists are rewarded for their publications. In 1800, fewer than 1,000 scientists were at work around the world. By 1900, the number had increased to 100,000, and by 1970 the number was estimated as 3,200,000.[2] From 80% to 90% of all scientists and academic physicians who have ever lived are at work today.[4] More than 70,000 are on the faculties of US medical schools.[5]

At the National Library of Medicine, 400,000 references are added annually to Medline, a bibliographic database of biomedical literature. The library subscribes to 20,000 scientific and medical journals and uses 138 miles of shelfspace to store its accumulation of books, journals, and periodicals.[6]

Pattee[7] has identified the way to solving the problem of information overload: "As systems grow in size and complexity, they reach a limit where a new level of hierarchical control is necessary if they are to function reliably."

There is little question that biomedical information has reached such a limit. Most people acknowledge that the new level of hierarchical control requires computerized information systems. But many of us are not prepared for the coming effects of information technology in our professional and personal lives.

The upheaval occurring today in information and communications technologies will force each of us out of our traditional ways of gaining access to, using, and managing information. Resisting this transition will put us at risk of rapid obsolescence in our professional activities.

Information technology

Several factors drive the addition of computerized information systems into medicine. Among these factors are:

- demands for rapid access to vast amounts of information;

Reprint request to: William R. Hendee, PhD, Senior Associate Dean and Vice President, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226. Copyright 1994 by the State Medical Society of Wisconsin.

- needs for more efficiency in response to greater constraints on health care costs;
- requirements to gain access to data from anywhere in space and time;
- availability of more powerful and affordable information and communications technologies; and
- pressures for health care reform and accountability.

Each of these factors creates a need to embrace computerized information services in medicine. Collectively, the five factors constitute an imperative for such services.

The use of sophisticated technologies to gain real-time access to information offers immense possibilities for changing health care delivery. Among these possibilities are:

- replace paper records with computerized data inventories;
- permit users to use multiple sense data rather than relying principally on printed information;
- offer images and visualization techniques as primary modes of communication;
- provide non-linear access routes to information through approaches such as Hypertext;
- require restructured organizational paradigms, especially decentralized administrative services;
- facilitate inter-institutional collaboration through networking (eg, Internet);
- substitute models, in many situations, for direct experience;
- demand continuous strategic planning; and
- redefine the fundamental meaning of work.

The last of the challenges, redefining the meaning of work, is perhaps the most intimidating to physicians. Computerized information and communications systems permit information and data to be treated as a resource to be obtained "just in time" in a manner similar to that recommended today for material inventories in business and industry. This approach to information access ultimately may profoundly affect the way academic disciplines are taught, especially medicine which today still depends strongly on the memorization of facts, systems, and protocols.

Institutional response

The management of scientific information is a major challenge for health care institutions obligated to help physicians and employees acquire and use information effectively. This challenge can be met only by establishing information databases and communications networks with terminals located conveniently throughout the institution and elsewhere. This approach requires administrative leadership characterized as[8]:

- vision, including acknowledgment of the problem of information overload and a perspective on how this problem can be managed through information technology.
- commitment, characterized as a willingness to invest in the technology and training necessary to help institutional members efficiently obtain and use information essential to their activities;
- reduction of institutional barriers that impede real-time access to information and data essential to biomedical research, medical education, clinical service, and policy formulation;
- customer advocacy, characterized as a recognition that the institution is in the business of providing services to customers, who are not only its employees and physicians but also members of the public, including patients and health care purchasers who use the instltution's services.

These features of administrative leadership are essential to guiding an institution and its members through the transition into successful management of scientific information. Without them, the transition is likely to be a troublesome process at best.

Fig 1.--Locations of institutions participating in the Medical College of Wisconsin Medical Information Network.

MCW's experience

The Medical College of Wisconsin (MCW) is committed to integrating effective information management into all its activities, including biomedical research, medical education, clinical service, and health policy guidance and analysis. This commitment is reflected in the establishment 2 years ago of the Health Information Technology Center (HITC), a service activity housed within the college's office of research and technology.

The mission of the HITC is to provide technology and training to support the effective acquisition and use of scientific information for medical research, education, and clinical service. The HITC provides various services to help institutional members accomplish their work through effective information management. Representative examples of these activities are described briefly below.

Information networking. The Milwaukee Regional Medical Center is a multi-institutional complex that

includes the MCW, John L. Doyne Hospital, Froedtert Memorial Lutheran Hospital, Children's Hospital of Wisconsin, Curative Rehabilitation Center, Blood Research Institute, and Milwaukee County Mental Health Complex. Faculty, house staff, and students of MCW are present in all of these institutions, as well as in the Zablocki Veterans Affairs Medical Center about 3 miles from MCW, 10 other health care institutions in metropolitan Milwaukee, and hospitals and clinics in Waukesha, Racine, and Kenosha.

On campus, several communications networks support the work of MCW members. These networks use fiber-optic cable pairs configured as Ethernet and token-ring communications channels for transmission of research, educational, administrative, and clinical information, including patient and billing data. The campus network is extended to remote institutions, including off-site hospitals, clinics, and offices through T1 leased lines, SMDS high-speed leased lines (for WiscNet/Internet connections) and a microwave link to the Veterans Affairs Medical Center. The campus communications network is evolving into three primary information lattices:

First is a clinical lattice, initially integrating laboratory, radiology and cardiology services between John L. Doyne and Froedtert Memorial Lutheran Hospitals, and eventually supporting all clinical services of the institutions. This information lattice is maintained continuously and includes build-in redundancy to avoid interruptions in service.

Second is an administrative and academic lattice supporting routine communications among the institutions and from the institutions into Internet. This facility is currently configured as an Ethernet network running several communications packages.

Third is a high-speed, high-volume lattice supporting research applications such as magnetic resonance imaging and gene sequencing experimentation that isolates these applications from the high traffic of other communications channels.

At MCW, Ethernet networks support departmental local area networks (LANs), work stations, and a multitude of terminals and personal computers. Connections to the Internet are bridged onto the MCW administrative and academic network. The college's faculty physicians and surgeons office, located 2 miles from the campus, is connected to MCW and several remote clinics through a large LAN employing leased T1 lines.

Fig 2.–Locations of members of the Wisconsin Ethics Committee Network.

Medical information network. One of the first major projects of the HITC has been the MCW Medical Information Network (MIN). The primary purpose of the MIN is to offer access from remote locations to a variety of information resources, including the

Continued on next page

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Continued from preceding page
journal and book collections of the MCW libraries and programs to search the biomedical literature. Several literature-search databases are available through the MIN.

In addition to these databases, the HITC provides access to a large number of databases useful in biomedical research, medical education, clinical decision-making, and health-policy formulation and analysis. For example, the Genetics Computer Group Sequence Analysis software package provides eight databases to assist researchers searching for known sequences of nucleic and amino acids.

The MIN allows the MCW libraries to function as a single entity in spite of its siting in four on-campus locations. MCW students, staff and faculty who have a computer and modem and a MIN password can gain access to all services of the MIN at no charge, except for a long-distance telephone charge when they are outside the 414 area code. The MIN also supports an electronic-mail operation, furnishes a monthly schedule of seminars, classes and special events, and provides access to Internet and Hytelnet.

Instructional projects

Students at MCW have used computerized approaches to learning for several years. The Instructional Technology Unit is an open-access microcomputer laboratory used for independent and small-group learning and testing activities for medical and graduate students. It currently offers 10 Macintosh and 13 IBM-compatible computers, with more than 80 instructional programs for student use. Half of the programs are authored by MCW faculty and staff, with the remainder obtained from external sources through purchase or field-testing arrangements. Several basic science courses for medical students are moving from traditional lectures to a case-based small group format with computer-oriented patient simulations to enhance clinical correlation. This transition is monitored by the faculty-level Curriculum and Evaluations Committee with the ultimate goal of acclimating students to life-long learning using information technologies.

Information technologies are transforming medical education at MCW by supplementing textbooks with computer-based demonstrations, models, simulations, and case histories. This transformation is focused especially on the transition of scientific and medical principles into clinical decision-making and patient-care activities. As a consequence, graduates today are learning how to enter the clinical arena and to keep up with the barrage of information they will have to cope with to remain current as health care providers.

In the 1-month, third-year ambulatory medicine clerkship, medical students are placed in rural-practices outside metropolitan Milwaukee. The college needs to maintain contact with these students for purposes of course management and educational and social support. The HITC is exploring ways to provide this link through computer networking. This activity is viewed as a prototype for providing communications channels to practicing physicians for purposes of teaching involvement, continuing education, and clinical consultation.

Community Outreach

The HITC has two missions. The resources and activities listed above have been described in the context of MCW students, staff, and faculty. Several of them, however, are available to physicians, institutions, and health care personnel outside MCW. For example, access to the MIN is provided for a nominal charge to 38 health care institutions outside the immediate MCW environment. A map showing the distribution of MIN sites outside Milwaukee is included in Figure 1.

Institutions participating in the MIN network have found its resources to be very useful for gaining computerized access to holdings of the MCW libraries, programs for literature searches and other services such as electronic-mail networking and consultation with MCW faculty. Additional connections with Wisconsin hospitals and clinics are solicited, with the number of possible connections limited only by license conditions for some software packages and the ability of the hardware to handle demand.

The National Science Foundation and the National Library of Medicine recently awarded a grant to support the HITC's role in outreach activities to physicians and other health care providers throughout Wisconsin. This outreach service, called MCW Connect, provides access to the Internet as well as to the services of the MIN. The MCW Connect project is helping the HITC to execute its goals of service, education, and community outreach.

A recent addition to the MIN network is rapidly gaining popularity as a resource to ethics committees in institutions throughout the state. This addition is the bioethics database, the use of which is encouraged by the 180 institutional members of the Wisconsin Ethics Committee Network (Fig 2). This database consists of continuously updated synopses of bioethics information abstracted from news releases, medical journals, legislative reports, and court decisions.

During the first 2 months the MCW bioethics database received almost 2,000 inquiries via Internet from locations as far away as Germany, Switzerland, Finland, France and Australia. The bioethics database is a unique MCW innovation, and consequently has no license constraints inhibiting its use by other institutions. Access to this resource and other services of the MIN and MCW Connect can be pursued by

calling the HITC office at (414) 778-4362.

Summary

Appropriate and accurate information accessible in a real-time, on-line manner is becoming essential to every aspect of medicine, including research, education, clinical service, and health policy formulation and analysis. This need demands a computerized information management approach not only to provide the required resources, but also to overcome the problem of information overload and anxiety associated with more traditional ways of accessing and using scientific and medical information. The HITC at the Medical College of Wisconsin is such an approach designed for use by students, staff and faculty.

Many of the information resources of the HITC are currently available to physicians and other health care providers outside the institution, and ways are being sought to expand these resources. The suggestions and interest of practicing Wisconsin physicians and other health care providers in the resources of the HITC are solicited.

Acknowledgments

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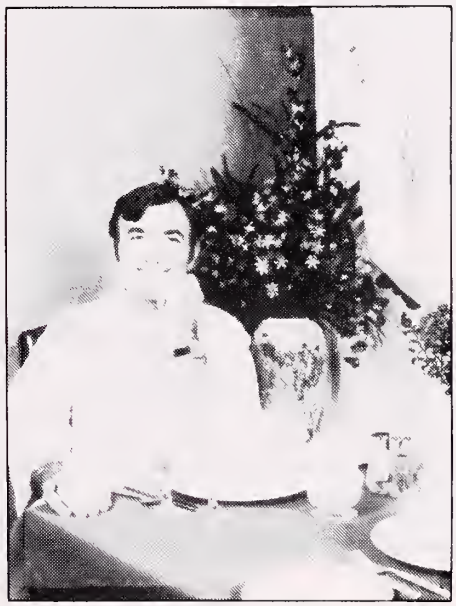

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A profile of geriatric trauma in southeastern Wisconsin

Verena T. Valley, MD; Holly Hepp, RN; Daniel J. DeBehnke, MD; Sarah W. Lawrence, RN; and Charles Aprahamian, MD, Milwaukee

The purpose of this study was to profile geriatric trauma in southeastern Wisconsin, including injury mechanisms, severity of injury, outcome, hospital lengths of stay, and total cost. We conducted a retrospective chart review of trauma victims over age 65 admitted to the Milwaukee County Medical Complex between July 1991 and October 1992. Cases were excluded if the patients had sustained isolated head or orthopedic injuries, thermal burns, or penetrating trauma. A total of 65 cases were studied. The population had a mean age of 75.8 ± 8.2 years; 53.8% were women and 46.2% were men. The leading mechanisms of injury were in decreasing order were motor vehicle crashes, falls, and auto-pedestrian injuries. The mortality rate was 29.2%. The mean length of stay in the hospital was 13.5 days. The total charge was approximately $1.3 million dollars. Motor vehicle crashes accounted for 61.5% of injuries. Safety devices and driver awareness programs may be under used in this population. The mortality rate is high with a moderate level of injury severity. *Wis Med J*.1994;93(4):165-168.

The most recent US census, completed in 1990, noted continued growth in America's elderly population. People 65 years of age and older now number 30.9 million.[1] Furthermore, the US Census Bureau projects those over age 65 will exceed 52 million by the year 2020 and will increase to 68 million by the year 2040.[2] Trauma is now the fourth most common cause of death in people over the age of 55 years and the fifth leading cause of death for patients over 75 years of age.[3] The elderly consume nearly $4.4 billion a year of health care resources expended on trauma care.[4] The purpose of this study was to profile geriatric trauma in southeastern Wisconsin including injury mechanisms, severity of injury, outcome, hospital lengths of stay and total charges.

Methods

This study was a retrospective chart review of multiple trauma victims over age 65 who were entered into the trauma registry at the Milwaukee County Medical Complex between July 1991 and October 1992. Only cases of patients admitted to the trauma service were included. Cases were excluded if the patients had sustained isolated orthopedic injuries, isolated thermal burns, penetrating trauma or were admitted to the neurosurgical intensive care unit (isolated head injury).

This exclusion criteria was patterned after other geriatric trauma studies to provide a meaningful comparison of multiply injured geriatric patients. Scores were calculated for each patient using the Glasgow Coma Scale (GCS), Revised Trauma Score (RTS), and the Injury Severity Scale (ISS) based on the 1985 revision of the Abbreviated Injury Scale (AIS).

Statistical comparisons were performed using the Mann-Whitney U test for nonparametric data. P values <0.05 were considered significant.

Results

Identifying data. Seventy-five consecutive cases met inclusion criteria. Ten charts were unavailable for review. The cases of 65 patients were studied. The population had a mean age of 75.8 ± 8.2 years; 53.8 % (35) were women and 46.2% (30) were men.

Mechanisms of injury. The leading mechanisms of injury were motor vehicle crashes, falls, and auto-pedestrian injuries (Fig 1). Motor ve-

Table 1.--Demographic data and measures of injury severity

	Survivors	Non-survivors	p
Number	46	19	_
Age (years)*	76.8 ± 8.0	73.3 ± 8.5	NS
Sex F:M	26:20	9:10	_
ISS*	14.4 ± 13.2	19.7 ± 13.8	NS
GCS*	14.1 ± 2.3	11.9 ± 4.8	0.008
RTS*	11.0 ± 2.5	9.1 ± 4.6	NS

* Expressed as mean ± SD

From the departments of emergency medicine and surgery of the Medical College of Wisconsin in Milwaukee. Reprint requests to: Verena T. Valley, MD, Box 204, Department of Emergency Medicine, Milwaukee County Medical Complex, Milwaukee, WI 53226. Copyright 1994 by the State Medical Society of Wisconsin.

hicle crashes were the predominant injury mechanism in our study population: 64.3% (27) of the elderly trauma patients were identified as drivers, and 35.7% (15) as passengers. Eighty-five percent (23) of the elderly drivers and 66% (10) of the passengers lived.

Safety belts were used in 57.5% of the crashes, safety belts were not used in 32.5%, and use was unknown in 10%. Airbag data was not reported in 92.3% of the crashes.

Falls were the second most common type of injury mechanism noted in our study population. They accounted for 16.9% (11) of injuries: 4 fell down stairs (36.4%), 3 fell from a ladder (27.3%), and 2 tripped and fell (18.2%). Fall distance was estimated to be less than 12 feet in 72.7% of the cases. Seven (64%) of the patients lived and four (36%) died.

Seven (10.8%) of our study patients were pedestrians: 4 (57%) lived and 3 (43%) died.

Indices of injury severity. Trauma scoring systems have been developed to allow comparison of injury outcome between trauma centers. These indices of injury severity are used in the evaluation of patients, in trauma research, and in continued quality improvement. The ISS and RTS are two of the most widely used trauma scoring systems.

The ISS is a numerical method for describing the overall severity of injury. The ISS measures the severity of anatomic injury and is an index derived from the AIS. The ISS values range from 1 to 75. Higher scores generally indicate more severe injuries. Studies have demonstrated that the ISS is correlated with mortality; lower correlations have been shown between ISS and length of stay and disability.[5]

Patient physiologic status on initial emergency department arrival is characterized by the RTS and is a function of admission values of the GCS, systolic blood pressure and respiratory rate. Lower RTS values are associated with poorer prognoses. The RTS has been shown to be a more reliable predictor of outcome than the trauma score.[6]

The GCS is a description of consciousness based on clinical examination of three specific types of behavior: eyelid opening, motor activity, and verbal activity. This scale has prognostic value after severe head injury.[7]

The mean ISS in our review was 15.9. The mean GCS was 13.5, and the mean RTS was 10.4. The ISS and RTS were not significantly different between survivors and non-survivors. The GCS was significantly higher in the survivor group (Table 1).

Outcome data. The mortality rate was 29.2% (19) of patients. Of the 46 survivors, 46.2% (30) patients were discharged home and 24.6% (16) were discharged to a nursing home or rehabilitation center.

Information on functional status prior to admission was available for

Table 2.--Length of stay and cost of medical care.

	Survivors	Non-survivors
Number	46	19
ICU stay* (days)	5 ± 6.1	6.2 ± 5.8
Hospital stay* (days)	14.4 ± 12.6	11.0 ± 14.5
Hospital cost*	$17,996 ± 27,362	$8,576 ± 11,212
MD cost*	$6,731 ± 5,139	$5,536 ± 16,624
Total costs*	$26,412 ± 32,620	$13,136 ± 16,624

* Expressed as mean ± SD

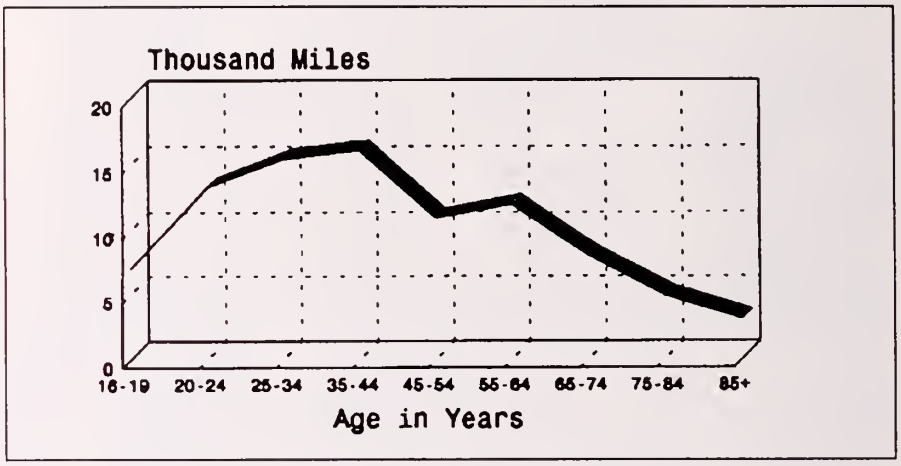

Fig. 2 — Average mileage per year for drivers in Wisconsin

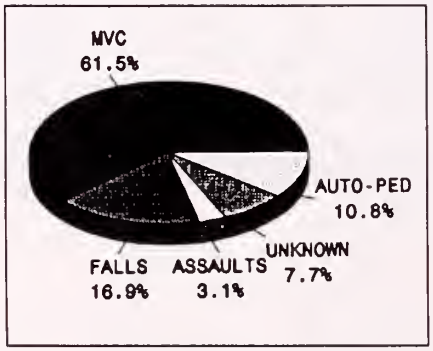

Fig 1 — Distribution of injury mechanisms for geriatric trauma, Milwaukee County Medical Complex.

53 patients: 94.3% (50) were functionally independent prior to their injury; 5.7% (3) were noted to have minor physical limitations prior to their injury. Of the 46 survivors, 50% (23) of patients returned to functional independence at the time of discharge, 30.4% (14) had moderate disability, and 19.6% (9) had severe disability and significant limitation of activity.

Length of stay and cost. The mean length of stay in the hospital was 13.5 days. The total hospital and physician charges for 55 of the 65 study casess (10 billing summaries were not available) approached $1.3 million.

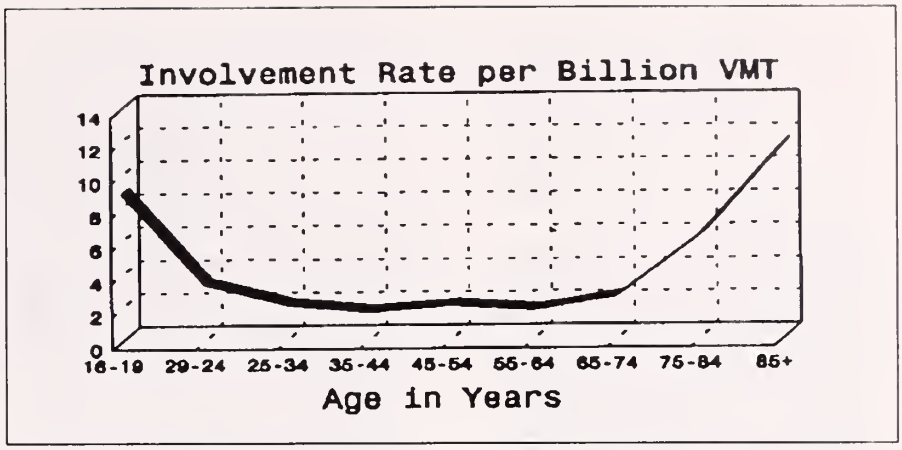

Fig. 3 — Fatal crash involvement per licensed driver per vehicle miles of travel (VMT)

Discussion

Motor vehicle crashes are a dominant mechanism of injury in elderly trauma patients. There are almost 499,000 drivers over the age of 65 years in Wisconsin.[8] Older Wisconsin drivers (over age 65) average less mileage per year than other age groups (Fig 2), but their involvement in fatal crashes is high and in sharp contrast to other licensed drivers when comparing vehicle miles of travel (Fig 3).

In 1989, the Wisconsin Department of Transportation began a driver awareness program for drivers over the age of 55. The program addresses topics such as driving ability and errors, as well as safety driving tips. Only 0.5% of drivers over age 55 participated in this program. It appears that the majority of patients in our study population were wearing safety belts; however, nearly a third (32.5%) were not. Information on airbag use was rarely documented on pre-hospital records and deserves further study.

The ISS and the RTS are widely used as predictors of patient outcome. Several studies have assessed the value of these scores for determining outcome in the elderly population. Oreskovich[9] noted that the mean ISS in a group of 100 elderly patients was nearly the same for survivors and non-survivors. Finelli[10] found the mean ISS for elderly non-survivors to be twice that of survivors in 180 elderly major trauma patients. The ISS and RTS were not predictive of survival in our study.

The overall mortality rate among hospitalized geriatric trauma victims has been reported to be in the range of 15% to 30%.[11] Our mortality rate of 29.2% falls into the high end of the reported range. Work by van Aalst et al[12] and DeMaria et al[13] have shown that the majority of survivors of severe injury (67%) returned to a functional level of independence. In our study, 46.2% of the survivors were discharged home from the hospital, while 24.6% were discharged to a nursing home or a rehabilitation center.

Hospital lengths of stay have been reported to be twice as long in geriatric trauma victims in comparison to younger patients.[9] Furthermore, DRG prospective payment has been found to grossly under-estimate the cost of care for these elderly, trauma patients.[9] Our study did not include an analysis of the DRG system and its effect on the Medicare reimbursement rate. The mean length of stay in our study was 13.5 days with mean total (hospital and physicians) charges of $22,478.00 (Table 2). The total charges for 55 of the 65 patients was $1.3 million dollars.

Summary

A sample of geriatric trauma in southeastern Wisconsin was retrospectively examined. Motor vehicle crashes account for the majority of our injury events. While older Wisconsin drivers average fewer miles, they are involved in more fatal crashes per vehicle miles of travel. Safety devices (safety belts, airbags) may be under-used in this population. Driver awareness programs are available for the older driver, but they are poorly attended. Mortality in this age group is high with a moderate level of injury severity.

A statewide emphasis should be placed on use of safety devices and attendance of driver awareness programs in this age group due to the high mortality associated with motor vehicle crashes.

Acknowledgements:

The authors would like to thank both Trudy Karlson, PhD, from the Center for Health Systems Research and Analysis, and Wesley Geringer, from the Wisconsin Department of Transportation, for their information and thoughtful comments.

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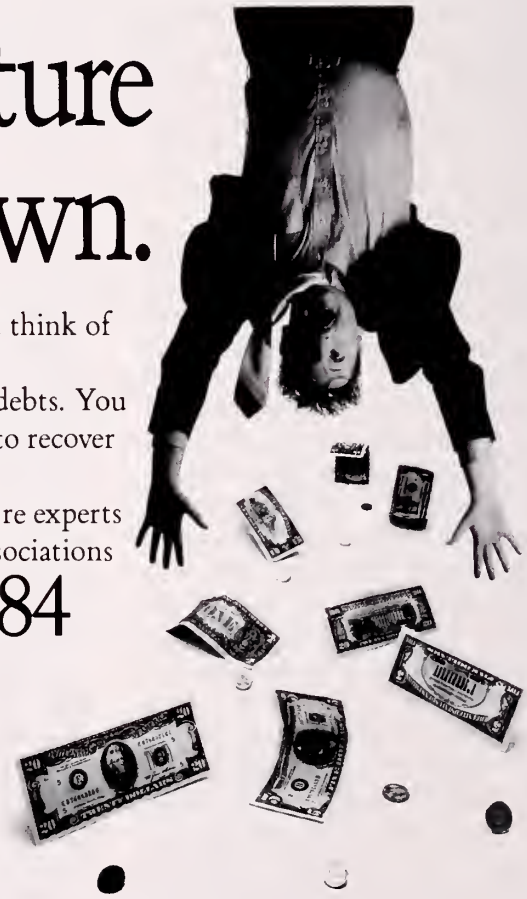

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Incarcerated hernia with intestinal obstruction after laparoscopic cholecystectomy

Marvin Wagner, MD, and George E. Farley, MD, Milwaukee

Use of laparoscopic surgical procedures have expanded in the past several years, but physicians must be cognizant of the potential complications. One such complication, intestinal obstruction, is discussed, as is the importance of CT scan in making a definitive diagnosis. *Wis Med J*.1993;93(4):169-171.

WITH THE ADVENT of the expanding use of laparoscopy, physicians must constantly be cognizant of the complications that can occur. Infection, bleeding, bowel perforation, and subcutaneous emphysema have all been reported in the literature.[1,2] In 1974, Schiff and Naftolin[3] reported a case of small bowel obstruction after an elective laparoscopic tubal ligation. This occurred at the infra-umbilical 12 mm access site. Thomas et al,[4] and Sauer and Jarrett[5] also reported an incarcerated hernia after a laparoscopic sterilization, and the latter a bowel obstruction after a tuboplasty. Both occurring through the umbilical access site.

Further search of the literature revealed that Bishop and Halpin,[6] Kiilhohma and Makinen,[7] and Hogdall and Roosen[8] reported herniation of omentum small bowel through the fascial defect created at laparoscopy for a gynecological procedure. Maio and Ruchman[9] reported on a post-laparoscopic incarcerated hernia after cholecystectomy, which occurred through the umbilical 10 mm access site and diagnosed by CT scan. We are reporting a similar case of a small bowel obstruction due to an incarcerated hernia through an 8 mm access site.

Case report

A 54-year-old obese female, who had a history of diverticulitis and a total abdominal hysterectomy, was seen for chronic cholecystitis with lithiasis. An elective laparoscopic cholecystectomy was done in the following manner.

Access sites of 8 mm were placed at the umbilicus and epigastric region (Fig 1), and a 5 mm access site was placed at the anterior axillary line and another 5 mm access site at the mid-clavicular line, both parallel to the umbilicus. During the procedure--because of the severe obesity of the patient, and because more exposure was needed to visualize the cystic and common duct--another 8 mm access site was created between the two 5 mm access

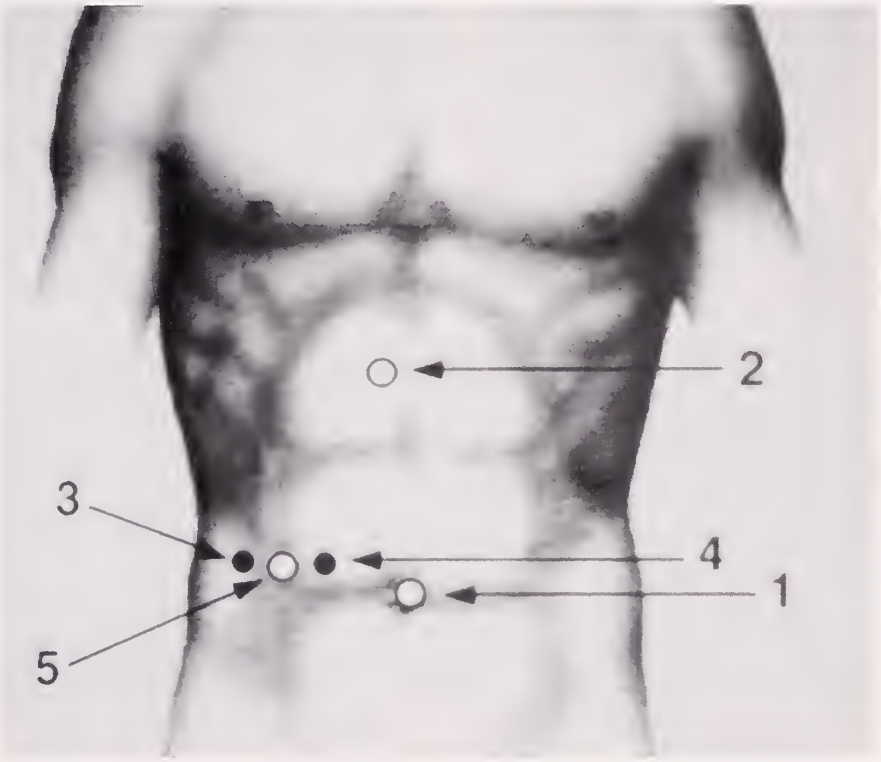

Fig 1. — Access sites: 1 and 2 are 8 mm; 3 and 4 are 5 mm; and 5 is the additional 8 mm access site through which the hernia is occurred.

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sites to place a retractor over the omentum and colon (Fig 1).

After the removal of the gallbladder, the abdominal cavity was decompressed and the access sites were closed with number (2-0) Vicryl sutures at the fascial level and a subcuticular skin closure with (3-0) catgut. The patient's post-operative course was uneventful, and she was discharged on the next day.

Five days after her surgery, the patient experienced abdominal pain, nausea and then "vomited." Examination showed an obese abdomen with moderate distention and mild tenderness over the right hemisphere of the abdomen.

An abdominal series (Fig 2) with supine and upright views demonstrated dilated loops of small bowel and small air fluid levels scattered throughout the abdomen. The patient was placed on gastric siphonage and supportive therapy. Her condition showed no apparent improvement after 24 hours, and at this time manifested more tenderness in the right side of the abdomen near the three access sites parallel to the umbilicus.

Because the patient was so obese, it was difficult to discern any masses or defect in the anterior abdominal wall. A CT scan of the abdomen was done (Fig 3), and it demonstrated a herniated loop of bowel on the right side, outside the muscle boundary of the abdominal wall. With these objective findings, the patient was taken to surgery, and a Richter's type of hernia was found through the 8 mm access site that was between the two 5 mm access sites (Fig 1).

The previously applied Vicryl suture in the fascia was completely "undone." The ability of the small bowel involved was completely intact. The 8 mm access site through which the hernia occurred was repaired by the Tom Jones procedure using the transversalis fascia and posterior and anterior rectus sheath. The patient's post-operative course was uneventful thereafter, with complete resolution of her bowel obstruction.

Fig 2. — Supine view of abdomen showing small bowel distention consistent with a small bowel obstruction.

Discussion

In most of the reports, the symptomatology of intestinal pathology occurs 3 to 7 days after the laparoscopic procedure. Common to all of the reported cases was the use of a 10 mm or 12 mm diameter trocar.

In this case, the patient's symptomatology started on the fifth post-operative day and occurred through an 8 mm access site. Several causes have been postulated as to the occurrence of this type of hernia, as well as recommendations for its prevention.

Because of the positive intra-peritoneal pressure after induction of pneumoperitoneum, a loop of bowel or omentum could protrude into the lumen of the trocar sheath on its

withdrawal.

With this in mind, it is essential to let the gas flow out of the peritoneal cavity before removing the sheath. Elevating the abdominal wall to separate it from the viscera has also been suggested. The "sine quo non" is to suture the fascial layer at the access sites.

It certainly is important to keep in mind the possibility of an incarcerated hernia when the patient experiences a symptom complex of intestinal obstruction after laparoscopy. Also, especially in obese patients in whom it is difficult to adequately examine the abdomen, a CT scan of the abdomen is helpful in discretely demonstrating the normal or pathological findings, as was demonstrated in this case.

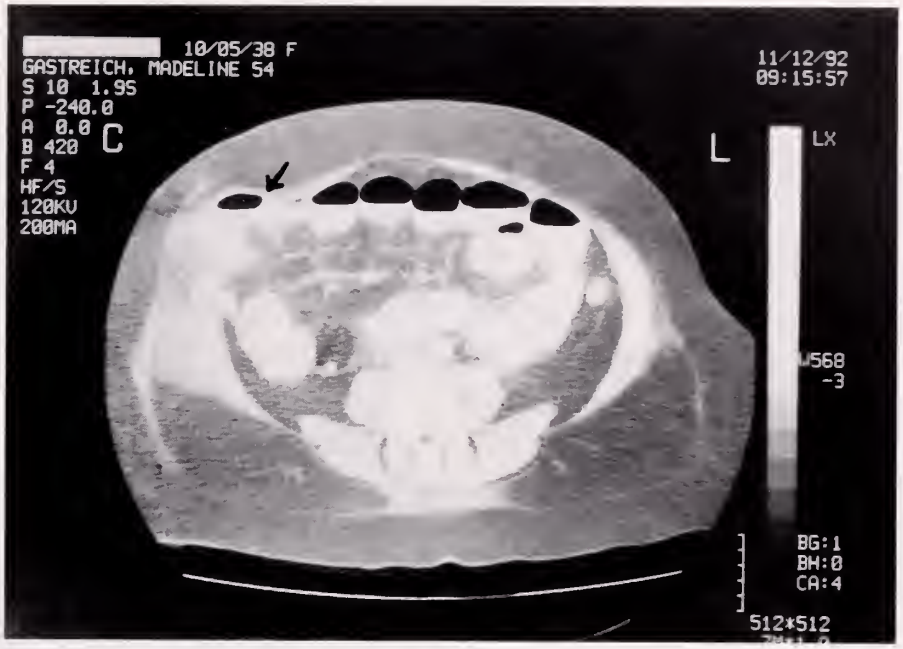

Fig 3. — CT scan of the abdomen post-gastrograffin oral contrast shows a single loop of small bowel herniated through the antero-lateral abdominal wall outside the muscular boundary.

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Public health

Self-reported cardiovascular risk factors among diabetics and non-diabetics in Wisconsin

Patrick L. Remington, MD, MPH, and Nancy E. Chudy, MPH, Madison

Diabetes is an important public health problem in Wisconsin. In 1992, diabetes was listed as the underlying cause of death on 1,043 certificates and a contributing cause on 2,423. Diabetes mortality in Wisconsin is one of the highest in nation, ranking the 11th among all states during 1980-1988.[1] Over the past decade, the diabetes-related mortality rate in Wisconsin has increased 10%, from 65.7/100,000 to 72.3/100,000, while the national rate has remained constant.[1]

According to data from Wisconsin's Hospital Discharge Survey, more than 6,000 persons are hospitalized with a principle diagnosis of diabetes each year (unpublished data). The average length of stay for each of these admissions is 7 days and the average charge is $8,000, leading to an annual cost of $50 million. Diabetes also contributes to hospitalizations for other diseases. Each year, there are 43,000 admissions with diabetes listed as a secondary diagnosis, 6,000 of these are for coronary heart disease. The charges for these diabetes-related hospitalizations exceed $350 million annually.

Fortunately, much of this burden is preventable. Lifestyle interventions, such as improved diet, exercise, quitting smoking, and control of high blood pressure, can substantially reduce a diabetic's risk of developing heart disease and stroke, the leading causes of death among diabetics. In this report, we compared the prevalence of risk factors for cardiovascular disease among diabetics with the rates among other adults in Wisconsin. This information can be used to support community-based health promotion activities, especially targeted to persons who are at risk of developing, or already have diabetes.

Table 1.-- Prevalence of self-reported diabetes in Wisconsin, 1989-1992.

Age	N	% Diabetic
18-34	2,332	1.4%
35-44	1,419	2.0%
45-54	790	4.6%
55-64	644	8.7%
65-74	641	11.5%
75+	479	11.6%
Sex		
male	2,921	4.2%
female	3,384	5.0%

Source: BRFSS, 1989-1992.

Methods

We used self-reported information obtained from the Wisconsin Behavioral Risk Factor Surveillance System (BRFSS). This is a random digit-dialed telephone survey conducted throughout the year to study health related behaviors among persons aged 18 years and older.[2]

Since 1989, the BRFSS questionnaire has contained questions about diabetes and other cardiovascular risk factors. Respondents were asked the question "Have you ever been told by a doctor that you have diabetes?" The question did not distin-

Continued on next page

The public health column is not reviewed by the *WMJ* editorial board. Dr Remington is chief medical officer for chronic disease in the Bureau of Public health, Wisconsin Division of Health. Chudy is an epidemiologist in the Section of Chronic Disease Prevention and Health Promotion, Bureau of Public Health. Reprint requests to Patrick L. Remington, MD, Wisconsin Division of Health, 1414 E Washington Ave, Room 96, Madison, WI 53704-3041. Copyright 1994 by the State Medical Society of Wisconsin.

Table 2.--Prevalence of selected cardiovascular risk factors among diabetics and non-diabetics in Wisconsin, 1989-1992.

Risk factor	Crude rate		Age-adjusted rate*		Relative risk**
	Diabetic	*Non-diabetic*	*Diabetic*	*Non-diabetic*	
Current Smoker	25%	25%	34%	25%	1.4
Hypertensive	51%	21%	42%	22%	1.9
Physically inactive	62%	55%	58%	55%	1.1
Overweight	48%	29%	46%	29%	1.6

Source: BRFSS, 1989-1992.
* To the 1990 Wisconsin adult population.
** Of the age-adjusted rates.

Continued from preceding page
guish those diabetics who required insulin and those who did not. Univariate analysis was conducted using SAS and responses were weighted to account for the complex study design. Data were age-adjusted to the 1990 Wisconsin adult population.

Results

According to the BRFSS, almost 5% of Wisconsin adults report that they have been told by a physician that they have diabetes (Table 1). Diabetes is more common among women compared with men (5.0% v 4.2%) and increases with age.

Compared with non-diabetics, diabetics were more likely to be hypertensive, physically inactive, and overweight (Table 2). Smoking rates were approximately the same. Because diabetes prevalence increases with age, and the prevalence of these risk factors also varies with age, these rates must be age-adjusted to make a proper comparison. Once adjusted for the differences in the ages between diabetics and non-diabetics, these data show that diabetics are 40% more likely to smoke, 60% more likely to be overweight, and almost twice as likely to have hypertension.

Comment

Diabetes is prevalent among Wisconsin adults--nearly one out of every 20 adults in Wisconsin has physician-diagnosed diabetes. Research suggests that there are nearly as many undiagnosed diabetics as those who are diagnosed in the population, indicating that Wisconsin may have a prevalence of close to 10%.[3] Based on this estimate, an estimated 280,000 adults in Wisconsin have diabetes.

Based on the findings from this telephone survey, diabetics are more likely to be obese, have hypertension, and smoke cigarettes. Obesity is the leading cause of non-insulin dependent diabetes, thus the finding of higher rates of obesity is ex-

Continued on page 176

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Continued from page 174
pected. Hypertension has been demonstrated to be more common among diabetics, and this combination substantially increases the risk of developing renal disease, heart disease, and stroke. Finally, the higher rates of smoking among diabetics substantially increases the risks of heart disease and stroke.

Wisconsin's *Public Health Agenda for the Year 2000* has set the following goals for diabetes for the year 2000 to reduce morbidity and mortality associated with diabetes, and to reduce the incidence of the complications of diabetes, including diabetic ketoacidosis, amputations, blindness, cardiovascular disease, and renal disease.

To help reach these objectives, the Wisconsin Division of Health has applied to the Centers for Disease Control and Prevention to establish a statewide diabetes control program. The request for proposals from the CDC represents a major shift in focus from previous CDC diabetes program announcements, and is designed to establish the program as a key component of an evolving health care environment. If funded, the Wisconsin diabetes control program will address the following four components:

- *epidemiology*: defining the burden of diabetes through surveillance and epidemiology;
- *health systems interventions*: improving opportunities for diabetes prevention and control through the existing and evolving health care system;
- *community-based interventions*: increasing opportunities for prevention, detection, and control of diabetes in communities (these efforts will be focused on high-risk populations); and
- *statewide coordination*: increasing the coordination of diabetes control activities in the state, by establishing a diabetes advisory committee.

During the first year, staff will define the burden of diabetes, establish a diabetes advisory committee, and build the diabetes network in the state. Work groups will be established to determine the needs for diabetes control in the evolving health care system and in communities with populations at high risk for diabetes. During the second year, a needs assessment will be conducted and the diabetes control plan will be completed, setting priorities for funding for the intervention phase (years 3-5).

The recent Diabetes Complications and Control Trial (DCCT) found that intensive therapy to maintain blood glucose concentrations close to normal effectively delayed the onset and slowed the progression of diabetic complications, such as retinopathy, renal failure, and neuropathy.[4] The DCCT results are encouraging for diabetics and providers alike. Nevertheless, efforts to improve glucose control will be much more effective if combined with intensive efforts to control blood pressure, reduce weight through exercise and diet, and quit smoking. Through such a combination of approaches, the public health burden from diabetes can be reduced.

Acknowledgements

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Wisconsin delegation joins unity demonstration on health system reform

SMS President Pauline M. Jackson, MD, of La Crosse, led a delegation of Wisconsin physicians participating in March 8 demonstration in the nation's capitol. More than 1,000 medical leaders from across the nation converged on Washington, DC, to demonstrate the unity of the health system.

The summit which was organized by the AMA, included presentations from Senators Kennedy, Dole, Dingell, Hatch, Chafee, and Graham and Representatives Cooper, Gingrich, McDermott and Rowland. While in Washington, the Wisconsin medical delegation met with most of the state's congressional delegation.

"Most of our lawmakers and Washington observers expect that some sort of system reform will pass before Congress recesses in August," Dr Jackson said. Representing Wisconsin physicians in Washington were: Richard Roberts, MD, Cyril "Kim" Hetsko, MD, and Paul Wertsch, MD, all of Madison; Ken Viste, Jr, MD, of Oshkosh; Timothy T. Flaherty, MD, of Neenah; and Brian McSorley, MD, of Milwaukee. ❖

Pauline Jackson, MD, (center) joins her fellow state medical society presidents in united support of health system reform principles during a March summit in Washington, DC.

SMS Board of Directors approves policy on reporting of domestic violence

THE SMS BOARD OF DIRECTORS voted to approve the following policy at its February meeting:

"It is of the utmost importance for Wisconsin physicians to recognize the prevalence of domestic violence in our state and assess patients for this abuse. In treating patients who are possible victims of domestic violence, the goal of intervention must be to help victims regain control of their lives. Therefore, it is vital that physicians pay great respect to a patient's right to **not** disclose domestic abuse or to refuse intervention when the patient believes such action is not in his or her best interest. The role of the physician in this process is to offer patients options and allow them to make the decisions in their lives. The patient's decision should be documented in the medical record.

There are, however, specific circumstances in which intervention must occur with or without the patient's consent. These situations are:

- If child abuse or neglect (anyone under age 18) is disclosed or highly suspect;
- If there is question regarding a patient's mental competency;
- If there are gunshot wounds or life-threatening injuries; and
- If the physician believes the patient to be at high risk for life-threatening or serious injury.

In the above circumstances, mandatory notification of appropriate intervention agencies should be explained to the patient. Providers should take care to assure the patient that such action is being taken to provide him or her with additional assistance; it is not punitive."

The Task Force on Domestic Violence, chaired by William J. Listwan, MD, also presented to the SMS board for information the following model protocol.

The assessment and treatment of victims of domestic abuse: model protocol

Definitions

- *Domestic abuse*: a pattern of coercive and controlling behavior (known as battering) that occurs in an adult intimate relationship, perpetuated primarily by men against women. Abuse takes many forms (physical, emotional, sexual, economic) and has an enormous effect on victims' physical and mental health.
- *Self-determination*: the inherent personal right to make decisions in one's own life.
- *Advocate:* a supportive person who understands the dynamics of abusive relationships and believes in people's right to live without fear of abuse. Advocates provide support, offer options, safety planning, and provide information about community resources.

Identifying battered women

Clues suggestive of abuse:

1. Extent or type of injury inconsistent with patient's explanation.
2. Findings that include:
   - multiple injuries and or injuries in different stages of healing;
   - injuries to the face, head, neck, chest, abdomen and genitals;
   - substantial delay between onset of injury and presentation for treatment;
   - injury during pregnancy (pregnancy is a high risk time for abuse);
   - presentation of seemingly insignificant trauma in relationship to the setting (emergency).
3. Symptoms or illness may include:
   - headaches or migraines;
   - musculoskeletal complaints (such as neckaches and backaches);
   - fatigue;
   - insomnia;
   - chest pain or palpitations;
   - gastrointestinal disorders (diarrhea, abdominal pain, colitis, ulcers);
   - chronic pain;
   - depression; and
   - anxiety.
4. Patient's history may include:
   - alcohol or drug abuse or addiction;
   - suicide ideation or attempts;

Continued on page 180

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Continued from page 178

- severe depression;
- repeated use of emergency services for trauma; and
- labeled as a "problem" patient, "crock," "hypochondriac," etc.

5. Patient's behavior may include:
   - distant or vague responses to questions;
   - jumpy when in presence of nurse or physician;
   - flinches in presence of partner;
   - flat affect, withdrawn;
   - crying or "hysterical";
   - nervous about leaving the hospital and going home; and
   - makes references to trouble at home, in the marriage, etc.
6. Accompanying partner or family member's behavior may include:
   - overly attentive or aggressive behavior;
   - answers all questions for the patient, controlling behavior; and
   - verbally abusive or rude to patient or hospital staff.

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Owen Brodie, MD, joined CompHealth's locum tenens medical staff in 1989, after 21 years in private practice. Since then he's worked in temporary assignments in state facilities, filled in for attending physicians, covered for private practitioners across the country.

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Assessing patients for abuse

The possibility of abuse in a patient's life should always be ruled out.

Asking patients about violence in their lives. The best approach is a direct approach. Experience shows that most people will talk about the abuse in their lives with their health care provider if they are asked sensitively and confidentially. Essential to the assessment process is creating a safe and confidential environment and establishing a trusting relationship with the patient.

1. Always interview the patient alone in a private area.
2. Convey an attitude of concern and respect for the patient. Avoid attitudes of frustration or blame. (Are you a friend or a threat?)

In addressing patients with physical injuries, a good question might be: "I see many women who require medical care with injuries similar to yours, often injuries caused by someone they know. Did someone you know do this to you?"

In questioning patients with symptoms or illness or serious psychosocial problems, the following types of questions are quite helpful in eliciting information about abuse:

- How are things at home?
- Do people get angry often? What happens when people get angry?
- Is there a lot of stress in your life right now?
- Is there a lot of conflict at home? What happens when your (partner, husband, boyfriend, son, etc) doesn't get his way?
- Have there been times during your relationship when there have been physical fights? Tell me more about that.

Other questions to ask might include:

- You seem frightened of your partner. Has he ever threatened to hurt you?
- You mention your spouse uses drugs/alcohol. How does your spouse act when he or she is drinking or using drugs?
- Does your spouse or boyfriend consistently control your actions or put you down?
- Sometimes when others are overprotective and as jealous as you describe, they react strongly and use physical force. Is this happening in your situation?
- Your partner seems concerned and anxious. Was he responsible for your injuries?

You may find it difficult to ask these questions. Asking questions and identifying the abuse in patients' lives is, however, the first step toward appropriate treatment. Explain that you ask all patients these questions because so many women are abused

by their partners. You want to know if this is happening to her so that you can offer assistance that meets her needs.

Intervention strategies

1. Patient discloses history of abuse:
   - Let patients talk about their experiences. Be open and willing to listen.
   - Convey to patients that they do not deserve to be abused and the abuse is not their fault;
   - Offer advocacy services to patient, explain role of advocates and services provided; and
   - If patient wants to meet with advocate, page on-call advocate as soon as possible.
2. Patient discloses history of domestic abuse, but does not want to see advocate, physician-nursing staff address the following:
   - Convey to patient that no one deserves to be abused and that the abuse is not her fault;
   - Remind her that the violence is against the law and she has a right to police intervention if she chooses.
   - Discuss her safety with her. Has she been injured in the past? Is she feeling a change in frequency or severity of his control, threats or abuse? Does she feel it is safe for her to go home? Does she want to go home? Does she have a friend or family member she could stay with? Does she know about the shelter? What has she tried in the past? Has she ever called the police? Does she have support or resources? Does she have children? Problem solve with her. Does she have an escape plan: a place to go in an emergency, ability to call the police, extra money hidden, spare keys to an apartment? car? Offer her a card or brochure to read (and keep if it is safe for her to do so.) Inform her about the resources in the community: shelter, hotline, support groups and advocacy services.
   - Some facts about abuse that are important to relay to her: Abuse usually occurs more frequently and becomes more severe over time. Watch for his patterns. She is not the cause of his violence, ever. (Her abuser is making a choice to be violent and usually will blame her for "causing him to be abusive.") She is a survivor. (Validate her strengths and the things she had done to survive through all this: Just telling someone is a courageous act. Help to empower her by pointing out positive steps she has taken.)

If during this process, you are unable to answer a question a woman may have, again offer an advocate to come and meet with her confidentially. You can contact an advocate for consult any time you are

Continued on next page

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5 4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

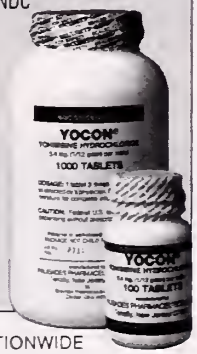
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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unsure of something.

3. Patient does not disclose abuse, yet it is highly probable that abuse is occurring:
   - Let woman know you assess all patients for abuse because it is so common and that you are a safe person to discuss what's happening in her life. For future reference, inform her of the supportive services available in your community. Services are free and confidential if at some point she feels she would like to talk to someone. Give her brochure or card.
   - Respect her right to not disclose the abuse. Remember, she is likely to be ashamed, embarrassed and scared. Do not display anger toward the woman for "lying" about the real cause of her injuries or symptoms. She is making a decision for survival and may not trust you, or the system, not to endanger her more. (This is especially true if she's already had revictimizing experiences from helping systems in the past.)

Intervention without patient's consent

It is of the utmost importance to respect a patient's right to not disclose domestic abuse or to refuse intervention. The goal of intervention with victims is to help them regain control in their lives. Crucial to this process is to offer options and allow them to make the decisions in their lives.

There are, however, specific circumstances in which intervention must occur with or without the patient's consent. These situations are:

- If child abuse or neglect (anyone under age 18) is disclosed or highly suspect;
- If there is question regarding a patient's mental competency;
- If there are gunshot wounds or life-threatening injuries; and
- If the physician believes the patient to be at high risk for life-threatening or serious injury.

In the above circumstances, mandatory notification of appropriate intervention agencies should be explained to the patient. Providers should take care to assure the patient that such action is being taken to provide him or her with additional assistance; it is not punitive.

Medical care and documentation of abuse

Medical care:

- Provide immediate medical care as dictated by patient's condition and department's standard of care.
- Be cautious in the prescription of tranquilizers or sedatives to battered women. Prescribing medicines that simply treat the symptoms, without addressing the underlying problem of abuse, may leave the woman more vulnerable to violence, and in most cases, supports her batterer's claims that she is the problem, she is crazy, etc. In addition, there is a high prevalence of suicide attempts among battered women, often using these same medications.

Documentation:

- Accurate documentation in the medical record is critical. Be mindful that you are putting together a data base of information. When bruises heal, your record may be all of the evidence that remains.
- Use neutral but descriptive language. Avoid using words like "alleges" that imply you do not believe what the patient says. Instead, use the patient "states."

Sources

This material was developed by the: Domestic Violence Project, Inc., a hospital-based advocacy project, 6308 Eighth Ave, Kenosha, WI 53143; (414) 656-8502; and based on materials from: *Identifying and Treating Adult Victims of Domestic Violence* by the New York Department of Health, 1990; and *Domestic Violence: Identification, Treatment and Referral of Adult Victims: Model Protocol*, New Jersey Department of Community Affairs: Division on Women, 1985.❖

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Dr Roberts meets "smoke-free kids" at state Capitol

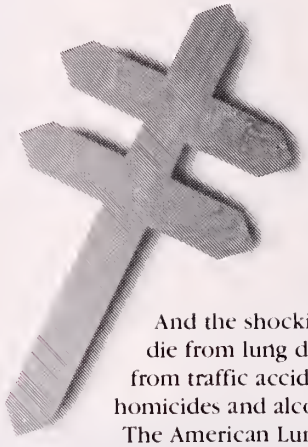
President elect Richard Roberts, MD, of Madison, joined members of the Tobacco-Free Coalition on March 16 at the state capitol for "Smoke-Free Kids at the Capitol." About 900 sixth graders from across the state joined Roberts and others in asking Wisconsin lawmakers to limit tobacco access to youth and tobacco advertising campaigns targeted children.

As part of the event, all legislators were given a copy of the surgeon general's recent report on youth tobacco use and a copy of the November issue of the *Wisconsin Medical Issue*, which featured several scientific articles related to smoking illness and death in Wisconsin.

Roberts proved to be a big hit with members of the Smoke-Free Class of 2000. The family physician chose youth volunteers from the audience to help with the rap and hold placards. The three rappers invited audience participation for the rap, "Smart kids don't smoke. 'Cause dead's no joke!"

Patrick Remington, MD, of the state Division of Health, and Warren Post, MD, of the Fond du Lac Tobacco-Free Coalition, also took to the microphone to encourage the "smoke-free kids" to stay on the healthy path and avoid the hazards of tobacco.❖

Everyone has a cross to bear.



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Physician briefs

The * indicates an SMS member.

Ewald Antoine, MD, is the medical director of the new outpatient mental health clinic in Cumberland, a subsidiary of Cumberland Memorial Hospital. Dr Antoine is a psychiatrist.

Mark R. Aschliman, MD,* has been named orthopaedic medical director of Columbia Sports Medicine. A Whitefish Bay resident, Dr Aschliman has been on the Columbia Hospital staff for 9 years.

Stephen Ty Denker, MD,* a cardiologist, has joined the Sheboygan Clinic. Denker is affiliated with Arrhythmia Consultants of Milwaukee, S.C. He received his medical degree from the University of Michigan-Ann Arbor, and completed an internship and residency at Borgess and Bronson Hospitals in Kalamazoo. He is board certified.

Wayne F. Heidenreich, MD, has joined Northwestern Mutual Life Insurance Co., of Milwaukee, as assistant medical director. Dr Heidenreich is a graduate of the University of Wisconsin Medical School. He completed his residency in internal medicine at Northwestern University in Chicago.

David Janssen, MD, has joined the medical staff at Ripon Medical Center. Dr Janssen, a graduate of the University of Wisconsin Medical School, has an office in Oshkosh. He completed an internship and surgical residency at Saginaw (Mich) Cooperative Hospital and a residency in plastic surgery at George Washington University.

Marshall Matthews, MD,* is the newly appointed medical director of oncology services at St. Nicholas Hospital in Sheboygan. A graduate of the University of Colorado medical school, Dr Matthews completed training in internal medicine and oncology at the University of Wis-

Continued on next page

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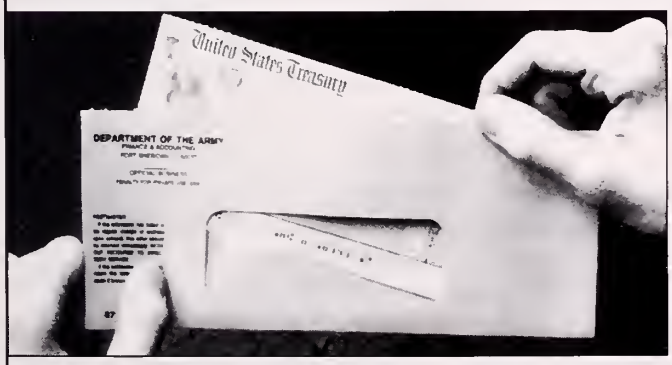

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Continued from preceding page
consin Hospital and Clinics. He joined Sheboygan Internal Medicine Associates, S.C., in July 1992.

Robert Merrill, MD*, is a new member of the medical staff of Bay Area Medical Center. Board-certified in family medicine, he is a member of the Marinette-Menominee Clinic. Dr Merrill received his medical degree from the University of Louisville School of Medicine and completed a rotating internship at O. Blodgett Memorial Hospital in Grand Rapids, Mich. He completed a residency with the Department of Family Practice and Community Health at the University of Minnesota.

Henry Najat, MD,* orthopaedic surgeon at the Monroe Orthopaedic Clinic, was recently elected president of the medical staff of Monroe Clinic. Dr Najat has been practicing in Monroe for 27 years. He is board certified.

Paul J. Rykwalder, MD,* of Menomonee Falls, has received a 3-year appointment as cancer liaison physician for the Hospital Cancer Program at Community Memorial Hospital.

William Simic, Jr, MD,* of Woodruff, has joined the staff of the Marshfield Clinic-Lakeland Center. An otolaryngolist, Dr Simic earned his medical degree from the University of Nebraska College of Medicine in Omaha. He served his residency at Geisinger Medical Center in Danville, Pa.

William Stekiel, MD, professor of physiology at the Medical College of Wisconsin, has received the American Heart Association's Harry S. Goldblatt Award in cardiovascular research for his studies of the effects of hypertension on blood vessels.❖

Obituaries

Anderson, John M., MD, died March 6, 1994, of a massive heart attack at the age of 52. He was born Aug 12, 1941, in Curtis, Neb, and received his MD degree in 1967 from the University of Nebraska at Omaha. He served in the US Navy for 2 years and returned to the University of Nebraska for his residency in obstetrics and gynecology, where he was chief resident. Dr Anderson was clinical assistant professor in the Department of Ob-Gyn at the University of Wisconsin Center for Health Services and medical director of the Madison Chapter of Planned Parenthood. He was a member of the American College of Obstetrics and Gynecology, the American Board of Obstetrics and Gynecology, the American Fertility Society, the Central Association of Ob-Gyn, the American Association of Planned Parenthood Physicians, and the American Association of Gynecologic Laparoscopists. He practiced onstetrics and gynecology with Dr Everett Roley and Dr Fred Melius in Madison. He is survived by his wife, Linda; three daughters, Chris Anderson of Marshall, Jennifer Cookin of Wauwatosa, and Katie Mahalick of San Diego, Calif; two stepsons, Michael Cote of Chicago and Sean Cote of Madison; an infant granddaughter, Kira Gookin; his parents, Huston and Leola Anderson of Maywood, Neb; and two sisters.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

Bauer, Carroll A., MD, died Feb 16, 1994, in West Bend at the age of 80. He was born May 23, 1913, in Beechwood. He received his bachelor's degree from the UW-Madison in 1936, and his MD degree from the University of Pennsylvania in 1938. He entered the US Army in 1942, serving in the European Theater during World War II. After his discharge, he served with the Army Reserve. Dr Bauer was a part-time

teacher at the former Marquette University Medical School from 1949 to 1965. In 1967, he joined the General Clinic in West Bend. He is survived by his wife, Anne; three sons, Robert of Madison, Terrence and Bruce, both of Coloma, Mich; seven grandchildren; and a sister.

Fifrick, Lloyd L., MD, died March 4, 1994, in Milwaukee. He was born June 10, 1911, in Stiles Junction. He received his degree from the University of Wisconsin-Madison. Dr Fifrick served in the US Navy from 1943 to 1946, and was awarded two Bronze Stars. For more than 40 years, he operated his family medical practice in Wauwatosa, and served as medical director of the Wisconsin Lutheran Home and assistant medical director of the Home for Lutheran Aging. Dr Fifrick was a member of the Medical Society of Milwaukee County, SMS, and the AMA. Survivors include his wife, Evelyn; a son, John of Rogersville, Tenn; two daughters, Ginny Haggard of Galveston, and Debra Fifrick of Wauwatosa; six grandchildren, four great-grandchildren; and a sister.

McNamee, James R., MD, died Feb 16, 1994, in Boscobel. He was born Feb 24, 1918, in Boyne City, Mich. He received his medical degree from the Marquette University School of Medicine in 1942 and did his internship and residency at Milwaukee County General Hospital. In 1944, he entered the US Army and served in both the European and Pacific theatres. Dr McNamee joined Dr E.M. Randall, Dr E.F. Freymiller, and Dr M.W. Randall in the newly formed Brookside-Parker Clinic in 1946. The same year the physicians purchased Brookside-Parker Hospital, which they later donated to the Boscobel Memorial Hospital Association. Dr McNamee retired after 51 years as a physician, in 1993. He is survived by his wife, Helene; four sons, Peter of Beloit, John and Patrick of Boscobel, and Paul of Blue River; two daughters, Maura McNamee Rolfe of Moscor, Russia, and Lise McNamee Emery of Portage; five grandchildren; and a sister.

Miller, Joseph F., MD, died Feb 21, 1994 in Madison. He was born Sept 21, 1908, in the town of Maplegrove-Brillion. He graduated from Marquette University Medical School and interned at St. Agnes Hospital in Fond du Lac and spent his entire medical career in Mt. Calvary. Dr Miller was a member of the SMS 50-Year Club. He was also a member of

Continued on next page

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Continued from preceding page
the Fond du Lac Medical Society, and the AMA. He is survived by his wife, Viola; eight sons, Joseph and W. James, of Fond du Lac, Delbert of Kohler, Matthew of Beloit, Mark of Kimberly, Michael of West Bend, John of Cedarburg, and George of Mt. Calvary; four daughters, Marilyn Kohlman, New Holstein, Catherine Thresher, Mesa, Ariz, Christine Danor, Fond du Lac, and Alice Steffen, Mt. Calvary; 36 grandchildren; 37 great-grandchildren; two brothers, and two sisters.

Peterson, Marvin G., MD, died Feb 14, 1994, in Brookfield. He was born June 10, 1899, in Geneva, Ill. He received his medical degree from the University of Minnesota. He served in the US Army during World War II. He was a physician in Lake Mills from 1925 to 1975. Dr Peterson was a member of the Jefferson County Medical Society and the SMS. He is survived by his wife, Martha; one daughter, Mary Siepmann of Hartland; five grandchildren; and four great-grandchildren.❖

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A call for papers

Gun violence
SMS President elect Richard Roberts, MD, hopes to help physicians fight the rise of death and injury from gun violence in Wisconsin during his term as president (1994-1995). In coordination with that campaign, the *Wisconsin Medical Journal* is seeking articles from Wisconsin physicians on the subject of gun violence, exploring its nature, causes, costs, effects and possible solutions. Scientific, socioeconomic and organizational papers, as well as letters, are sought for a special issue.

Medical diversity
The *WMJ* is also seeking articles on providing health care to Wisconsin's minority communities. If you are serving a significant minority patient base, or are studying the delivery of health care to minority populations, please consider submitting a paper on your findings to the *WMJ* for possible publication in a special issue.

Soundings
Where have our creative writers gone? Share your personal experiences of special significance, your poetry or your short stories with your colleagues through the *WMJs* "Soundings" feature. Of course, your "Soundings" should be related, in some way, to your being a physician.

Authors guidelines
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EMERGENCY MEDICINE: Moonlighting opportunities in low volume ED beginning July 1, 1994. 30 minutes northwest of Milwaukee. Friendly and progressive hospital. Excellent compensation relative to volume, malpractice negotiable. Call 414-332-6228 or send CV to the Emergency Resources Group, 509 W. Montclaire Ave., Milwaukee, WI 53217. 4-5/94

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FAMILY PRACTICE PHYSICIAN needed to join established group of five FPs and one Pediatrician. Northwestern Wisconsin community of 8,000 with service area of 40,000, located on the doorstep of Wisconsin's fabulous lake country. Practice medicine in a small family-oriented community within two hours of Minneapolis/St. Paul. Competitive salary and excellent fringe package. Send CV to James A. Volk, M.D., Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 4-6/94

FAMILY PRACTICE physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to James A. Volk, MD, Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 4-6/94

MILWAUKEE AREA. A rapidly expanding 70 physician multi-specialty clinic seeks BC/BE physicians in the following specialties: family practice, internal medicine, urology, oncology, psychiatry, and OB/Gyn. Competitive salary, excellent fringe benefits. Address inquiries and CV to: Medical Associates Administrator, PO Box 427, Menomonee Falls, WI 53052-0427. 3-7/94

IOWA - FAMILY PRACTICE - Salary guarantee and loan forgiveness. Minimal politics, new physician offices connected to hospital, call 1:5. Contact Laura Hays, 800-765-3055, 222 S.Central, Suite 700, St. Louis, MO 63105, FAX 314-726-3009. 3-4/94

OSHKOSH, WISCONSIN - Medical groups are recruiting in Family Practice, OB/GYN, Internal Medicine, Emergency Medicine, Pulmonology, and Orthopedic Surgery. Mercy Medical Center has an active medical staff of 150 physicians in all medical specialties. Oshkosh is an attractive community of 55,000 people, located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley (metro area of 350,000 people). University of 12,000 students. Good local schools. Low crime area. Contact: Christopher Kashnig, Mercy Medical Center, 631 Hazel Street, Oshkosh, WI 54902. Call 414-236-2430. Fax 414-236-1312. 3-4/94

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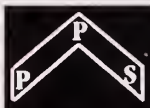

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2/93;TFN

Medical Meetings-Continuing Medical Education

THIRD ANNUAL CLINICAL NEUROLOGY AND BEHAVIORAL SCIENCES SYMPOSIUM: Acute Neurological and Psychiatric Illness, Friday, May 20 - Sunday, May 22, 1994. Landmark Resort and Conference Center, Egg Harbor, Wisconsin. Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449. 1-800-541-2895. 4-5/94

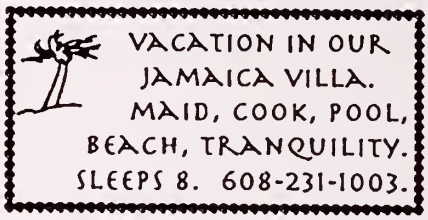
"Leflunomide: A New Direction in Immunosuppression" will be the topic of the Fifth Annual Rush Symposium on Transplantation. The symposium will be at Rush-Presbyterian-St. Luke's Medical Center in Chicago on Saturday, May 21, 1994, at 9:00 a.m. The rapidly advancing technology in anti-rejection therapy has led to a new and promising direction in immunosuppressive drugs, specifically the novel drug Leflunomide. Leflunomide has many promising properties including its ability to prevent and reverse allograft rejection, to downregulate alloantibody production and to provide exceptional control of concordant xeno rejection, placing it high among the small group of evolving drugs with potential for clinical transplantation. A series of lectures describing its action in rodents and in dogs in various transplant models, its mechanism of action and the early expanse in human use will be presented in this day long symposium. To register for the symposium or for more information, please call the Transplant Program Physician Relations Coordinator at 312-942-6242. 3-4/94

Medical Meetings-Continuing Medical Education

AMA

June 12-16, 1994: Annual AMA House of Delegates, Chicago.
December 4-7, 1994: Interim House of Delegates, Honolulu.

Miscellaneous



4-6/94

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association.*

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Contents

May 1994 Vol. 93 No. 5

Opinions

195 *President's page*
On making the difference
by Richard G. Roberts, MD, Madison
196 *EVP report: The view from here*
Making the SMS world a little bit safer
by Thomas L. Adams, CAE, Madison
198 *Editorials*
Percentages must go
by Russell Lewis, MD, Madison
198 Primary care and nurses
by Richard D. Sautter, MD, medical editor
200 *Letters*
Recruiting effort draws fire
by Geoffrey Kloster, MD, Galesville
201 Reform must fill the Medicare gaps
by Norin Elfton, The Gray Panthers, Denver

Scientific

203 Vitamin B_{12} replacement therapy: how much is enough?
by David T. Watts, MD, Madison
207 Trends in the stage of cancer at the time of diagnosis
by Philip N. Redlich, MD, PhD; Timothy L. McAuliffe, PhD; Lisa A. Robinson, RRA; and Kathy L. Reith, RRA, CTR, Milwaukee
212 Unusual complication of coumadin toxicity
by Prakash Shah, MD, PhD; William Kraklow, MD; and Geoffrey Lamb, MD, Milwaukee

Socioeconomic

217 *Public health*
Regional differences in smoking rates among women giving birth in Wisconsin, 1990-1992
by Darren Bush, MA; Susan Latton; Susan Uttech, MS, CHES; Richard Aronson, MD, and Patrick L. Remington, MD, MPH, Madison
219 *Wisconsin peer review*
The health care quality improvement program
by Jay A. Gold, MD, JD, and Barbara D. Heuer, RN, Madison
222 AMA compiles "railroad Medicare" complaints

Organizational

225 Mike^2: A potent formula for organized medicine
by Shari Hamilton, assistant editor
230 Physician briefs
230 Kirby appointed to AMA advisory group
231 SMS enters agreement with electronic claims network
233 County society news
233 Request for bids issued in Waukesha County
235 Obituaries
237 *Wisconsin Medical Journal* instructions to authors

Our cover: Our cover story begins on page 217. Photo courtesy of the March of Dimes Birth Defects Foundation.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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President's page
On making the difference

AMERICAN MEDICINE means change. That has always been true. What is different today is the rate of change. The doubling time of medical knowledge is now 6 to 7 years. That means that half of everything that we depend on today taking care of our patients will be out of date, incorrect, or incomplete by the end of the decade. Even more unsettling is the rate of change of the business of medicine. Mergers, acquisitions and vertigrations are becoming all too familiar phrases in the doctor's lexicon.

In the midst of these changes, physicians often feel isolated, strangled by red tape, or portrayed by the media as entrepreneurs in need of reform. But we know in our hearts that is not who we are. We are not industrial cogs turning mass produced diagnoses filling one-size-fits-all health care. We are men and women who have chosen to dedicate our lives to the service of others. We are a unique group of individuals: diverse in gender, political beliefs, and ethnic background. We practice medicine in diverse settings: from offices to public health clinics; from intensive care units to operating suites; from laboratories to classrooms.

Our diversity is our strength; our commonality is our compassion. We share common goals, common challenges and common dreams. Our greatest rewards do not come from financial bottom lines, but from memorable times. Laser-like images burned into our memories never to be forgotten. The time the limp victim of a near-drowning was restored to a 6-year-old bundle of energy with an in-your-face attitude; the once withdrawn 87-year-old rejoicing over newfound sight and independence after cataract surgery; the triumphant first-time mom snuggling her newborn.

But not all of our memories are pleasant. We bear witness to much suffering and pain, and it can grind us down: the teen who put a 9mm slug through the base of his brain; the 24-year-old woman rendered ventilator-dependent in a drive-by shooting, who ruminates on what might have been with a right turn, rather than a left turn, at that fateful street corner.

We can reclaim our heritage and determine our destiny. We have much to hope for and much to share. Our dedication to the public good extends far beyond the walls of hospitals and clinics. We must reach out to our communities through public health and other civic activities. Our voices can and must be heard on health boards and before school boards; in town halls and within capitol walls. Medicine's torch has been passed to us. Let future generations of physicians look back on us and say that we held the torch high, that we lit the way to a better health system, and that we continuously renewed our commitment to serve. Let them say that we gave our time, our talents, ourselves; that we gave our communities the possibility of hope; that Wisconsin physicians together with their communities made the difference.❖

Richard G. Roberts, MD, JD

EVP report: The view from here
Making the SMS world a little bit safer

As of July 1, when you visit the SMS headquarters in Madison you will notice a couple of changes in our building security system. The changes are necessary responses to a world and a body of tort law that are not always changing for the better. We have, however, worked to keep these changes as unobtrusive as possible. Our goal is to provide the SMS staff, members and visitors a greater level of security without undue disruptions.

The change that will be most noticeable to you is that when you enter the SMS building, you will be asked to clip on a member name tag. If you are attending a scheduled SMS activity, such as a commission meeting, you will find a preprinted name tag waiting for you. If you are just dropping in or have an appointment with a member of our staff, you will be asked to stop at the front desk and pick up a badge, and to drop it off at the front desk as you leave the building.

All SMS staff and all visitors will also be wearing name badges while they are in the building.

One of the nicer side effects of the new system will be that our entire staff will immediately recognize you as a member physician. Few of our staff have the opportunity to meet physicians in the field or at meetings, but during the course of a typical year we have more than 1,000 physician visits to SMS headquarters and we hope the new system will enhance the value of those visits. Getting to know you better is one of the first steps in intensifying our service-to-members philosophy.

Another change you may notice is that all exterior doors, except the main entrance, will be kept locked at all times (as will the door to our main computer room). The front door will be unlocked during normal business hours. Surveillance cameras, operating around the clock, will keep an eye on all doors and loading docks.

Don't worry: We have not experienced any serious security problems at SMS headquarters. We would like to keep it that way.

Pick up any newspaper, turn on any news broadcast, and the trend toward a more violent America is evident in the headlines. Why we are heading in this direction and how we may change direction as a culture are questions we should all be asking, but in the meantime we need to do what we can to protect ourselves and each other.

Part of the increased violence in America is found in the work place--so much so that counseling employers on the legal issues associated with work place violence has become as much as 10% of some law firms' business. Last fall, the Society of Human Resource Management surveyed 479 companies: more than one third reported violent incidents at work. In 1992, work place violence cost employers an estimated $4.2 billion in lost work and legal expenses. Not only does violence damage the lives of valuable employees, it can burden the employer with higher costs for health care, lawsuits, Workers' Compensation premiums and other expenses.

Thomas L. Adams, CAE

The legal liability threat is not insignificant. An emerging body of tort law suggests that companies large and small should adopt policies and procedures that better define what they are doing to prevent work place violence. The courtroom terms are usually something like "failure to exercise reasonable care and due diligence." (As with other legal employment standards, this applies with equal force to physician offices.) Our new security system is an effort to exercise that care and diligence, and thereby protect SMS assets from legal threats.

I am confident that the new procedures will not make your visits to SMS headquarters any less pleasant or productive, but any time a new system is implemented "bugs" are discovered and must be worked out. If the new system creates a problem, please let us know. We are here to serve.❖

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Editorials

Percentages must go

Twenty-five to 40 years ago at our clinic, in December every department or doctor reviewed charges for each procedure performed and then set the fee for the next year. About 15 years ago, management suggested we allow them to raise our established fees by an agreed-upon percentage across the board. It seemed logical and certainly was simple. It was also, we were told, the common practice and had the support of insurance companies and government agencies.

Two unfortunate things happened as a result of our doctors' acceptance of this philosophy. First, and least important, it helped promote the idea that medicine was becoming a business, not a profession. When a doctor sends the patient a bill for $26.32 for an office call it is about the same as buying groceries at the supermarket. A charge of $26 or $27 would be more professional.

The most important effect, however, was what this action did to the income of procedure-oriented physicians to the detriment of those doctors rendering primary care. In the 1980s, fee increases tended to be 5% to 15% or more annually. If the increase was 10%, a cardio-vascular surgeon charging $3,000 for a coronary bypass saw the fee go to $3,300 and the gastroenterologist found the charge for a flexible colonoscopy go from $800 to $880. The primary care physician saw the fee going from $30 to $33 for an intermediate office visit.

The result, predictably, was that doctors who did expensive procedure-oriented medicine put an increasingly significant amount of money on the books without having to work any harder. Because physicians' income depends in large part on their productivity, as measured by their charges, a disparity in that income was created and every year it was made much worse.

As should be anticipated, this has made it more financially desirable for medical school graduates to enter the specialties rather than the more badly needed and--for most young women and men--the more attractive and challenging field of primary care.

Medicaid is raising reimbursement for primary care by 1% to 2%. This may be a step in the right direction, but if the purpose is to make primary care more attractive it is too little too late. A 1% increase in a $1,000 procedure is $10, but for a $30 charge it amounts to 30 cents. The entire reimbursement issue demands rethinking the methodology--and dropping the percentage approach.

I have been encouraged to hear that some groups are trying to do this. With RBRVS seemingly in place, now is the time to use the old approach of evaluating each procedure on an annual basis, going either up or down as needed. New procedures, especially when expensive equipment is involved, might often find the cost declining after a proper time.

Organized medicine might get involved and help not only with establishing the methodology of establishing fees, but also lead in getting governmental payors and insurance companies to accept replacing the percentage increase program with something more equitable.

--Russell Lewis, MD
Madison❖

Primary care and nurses

Much has appeared in the media of late regarding nurses providing primary care. This idea is very strongly supported by the Clinton administration, most likely because of possible cost savings.

I have great respect for nurses, as I feel most doctors do. Without their help, it is impossible to provide even adequate care. Expert care in very large part depends on the quality of the nursing staff. Still, I have a problem with nurses doing primary care without supervision.

For a number of patients seeking primary or urgent care, the diagnosis is obvious. In a smaller percentage, however, the diagnosis is elusive and will require problem solving skills and the depth and breadth of knowledge obtained in medical school.

The difference in education is not the only problem with the idea of unsupervised nurses providing primary care. The idea also raises ques-

tions involving malpractice, hospital admissions, charges, referrals, surgery, subspecialty designation, certification and the MEB, to name a few.

Providing care without supervision, nurses will be at risk for malpractice claims. I would expect that most claims would be the result of errors of omission. This is a significant risk. Recently, I was involved as an observer in a claim that was settled for more than $1 million because the attending doctor missed the patient's breast cancer. Will the nurses be covered by the state's umbrella or be covered by some other insurance provider? The medical liability tort system has been out of control for a long time, and remains so today. Will not the addition of nurses' liability only fuel the fire and further add to the cost of medicine?

The concept appears to be attractive to the Clinton administration chiefly because in the first few years, charges by nurse practitioners will be less than charges by doctors. But sooner or later the cry will be "equal pay for equal work"--as would seem right--and the advantage of lower nurse charges will evaporate.

For a few years, nurse practitioners will concern themselves with the outpatient practice of medicine. In the not too distant future, however, they will ask to admit their patients to the hospitals as the natural progression of their care.

As the nurses provide more than

Continued on next page

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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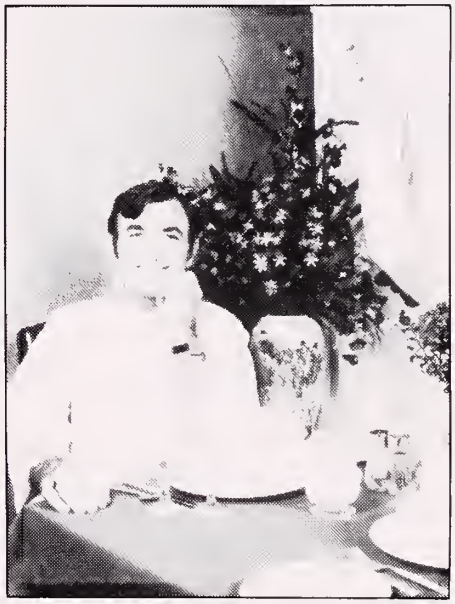

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Continued from preceding page
first aid in emergencies, they will feel more and more comfortable with minor surgery. At some time, the minor surgery will require more than local anesthesia and the nurses will enter the operating room as the surgeon. It is then, a short trip to elective surgery--perhaps a D&C for starters. Because most nurses are women, this will seem quite natural to many. This would only be the camel's nose under the tent. The next step would likely be breast surgery, followed by surgery on female pelvic organs.

There is more to surgery than manual dexterity: namely the skills and judgment obtained by completing medical school and surgical residencies.

Who will certify these nurse practitioners? The MEB? A new board? What will be the requirements? Subspecialty designation for nurse practitioners is already occurring.

I am certain that many nurses want to escape the "tyranny" of physicians, which may account for their strong support of this concept. Certainly, there is a shortage of primary care doctors, but I do not feel asking nurses to fill the gap is the correct solution. Placing primary care doctors at the top of the compensation pyramid would be a much better solution.

--Richard D. Sautter, MD
medical editor❖

Letters
Recruiting effort draws fire

TO THE EDITOR: Several years ago, I sent a letter to the SMS complaining of its solicitation tactics in efforts to induce me to join the AMA. This year, however, I think the impropriety is beneath any but the sleaziest of fly-by-night operations.

The enveloped the request comes in states in large letters, "MEMBERSHIP DUES NOTICE ENCLOSED." The return address is the State Medical Society of Wisconsin. The implication is very strong that the membership has already been agreed upon. In many physicians' offices, this would go to the business manager, who would pay the appropriate amount requested. The notice on the inside is simply a dues notice with only a subtle comment to the fact that the recipient is being asked to join, leaving the impression to anyone who does not read the notice word-for-word that the joining has already been done and this is a simple previously agreed upon bill.

This is an obvious and outright attempt to cheat the SMS members through trickery. The word "cheat" is strong language. I have never used it before in relationship to SMS, nor to any other established medical society. The tactics used, however, cannot be described by any language less severe than this.

As an organization claiming to watch over the health care of all the citizens of the state, your credibility is absolutely zero when you openly defraud your own members. Regardless of the professed intent of the SMS, I cannot in good conscience maintain a membership in an organization that obtains money from its members or from others by fraudulent means.

Please inform me of the decision of the SMS Board of Directors regarding next year's solicitation plan before next year's dues notice is mailed.

--Geoffrey Kloster, MD
Galesville

Editor's note: The SMS believes that the *recruiting* nature of this direct mail piece was clear; certainly there was no intent to defraud or mislead the targeted audience. No other complaint about this recruitment mailing has been heard from the approximately 3,000 SMS physician members who received this mailing.❖

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Reform must fill the Medicare gaps

To the editor: On Monday, April 18, in Milwaukee, President Clinton spoke to the employees of Ameritech pushing his health care plan. As usual at such meetings, they dodged the impact of the Medicare program.

I have a government report. It says that Medicare paid out $142.9 billion in fiscal 1993. That's a 10.6% increase over 1992. Such numbers show that the Congress cannot well ignore the Medicare program

I and my colleagues have a simple way of evaluating every health care reform proposal. Does it absorb the Medicare program? If not, it is instantly suspect and we equate its effectiveness to the rearranging of the deck chairs on the Titanic.

Medicare is national health insurance for senior citizens. It is a useful program but it has always been missing important parts. Three examples are; Medicare pays less than 80% of the cost of surgery, Medicare skimps on convalescent care, and Medicare does not pay for prescriptions.

Will the Congress fix the missing parts of Medicare? Certainly, the Congress cannot dodge indefinitely: some 32 million senior citizens are enrolled in Medicare.

About 40% of senior citizens have the missing parts of Medicare paid by former employer. The remaining 19 million seniors are forced to pay the missing parts out-of-pocket. This is a serious drain on fixed retirement incomes.

I have long proven to myself that it is essential to fix the missing parts of Medicare. It seems to me that the best way is a health care payment system that includes all Americans, and does not leave senior citizens standing on the side under a separate program.

--Norin Elfton
The Gray Panthers
Denver❖

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Interactive Dialogue with AMA Board of Trustees

HMSS representatives will not want to miss this year's AMA-HMSS Annual Assembly Meeting held on **June 9-13** in Chicago. Aside from the usual policy-related activities, representatives will have an opportunity to dialogue with the AMA Board of Trustees, hear the latest news and information from Washington, and learn the importance of and methods for physician involvement in health system reform.

The Friday education program hosts an impressive panel of speakers. From their remarks, representatives will learn: the impact of proposed legislation on the future practice of medicine; the kinds of managed care entities most likely to thrive; the ways to cope with health care delivery changes at the local level; the support needed to pass legislation on physician involvement in health system reform; the steps for developing a physician-directed health delivery network or plan; and the best methods for managing patient care and physician compensation in physician health plans.

Physician Involvement in Health System Reform

With health system reform legislation pending before Congress, state health system reform initiatives, and the rapid development of integrated delivery systems, it is vitally important that medical staffs mobilize to stand up and speak out for patients and the profession. The June Assembly meeting is no exception. Now perhaps more than ever before, HMSS representatives need to be involved in shaping the nation's future health care system.

HMSS past actions have made a difference. The AMA has incorporated many issues advocated by HMSS in its new health system reform proposal for action and model legislation. Basically, the draft bill:

- requires that health plans establish a medical staff structure with defined rights with regard to the plan's medical policy, utilization, quality and credentialing and management issues;
- expressly permits physicians to jointly present their views on any plan issue (without boycott or strikes) to plan management for discussion and negotiation;
- directly aids physicians in the creation of their own plans or networks to compete with large insurance companies;
- requires negotiation of new regulations with the profession before their announcement ; and
- expands the role and protection for the profession's accreditation, standard setting and medical society disciplinary functions.

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Vitamin B_{12} replacement therapy: how much is enough?

David T. Watts, MD, Madison

Vitamin B_{12} deficiency becomes increasingly common with advancing age. Diverse recommendations exist for initial and maintenance therapy of deficiency states. With cyanocobalamin, the only B_{12} preparation available in the United States, much greater amounts of the vitamin are retained with a 1000 μg injection than with 100 μg, with no disadvantage in cost or toxicity. Maintenance therapy using the larger dosage may be necessary to meet metabolic requirements in many patients. Thus, it is recommended that parenteral regimens use 1000 μg cyanocobalamin: 5 or 6 biweekly injections for loading, and once-a-month for maintenance. Oral therapy with 300-1000 μg per day may be therapeutically equivalent to parenteral therapy. *Wis Med J.1994;93(5):203-205.*

Vitamin B_{12} deficiency is common in elderly persons. Pernicious anemia, the prototypical deficiency state, has a frequency of 0.1% to 0.2% overall. In those older than 65, however, the frequency may reach 2.5%.[1] Patients with B_{12} deficiency may have vague symptoms, such as fatigue or anorexia, as well as neuropsychiatric problems.[2] The latter may present without hematologic abnormalities.[3,4] This paper highlights some of the differing recommendations for B_{12} replacement therapy, and applies knowledge of cobalamin metabolism in guiding selection of therapy.

Dr Watts is an associate professor with the University of Wisconsin's section of geriatrics and gerontology. Reprint requests to: David Watts, MD, Rm 2245 Medical Sciences Center, 1300 University Ave, Madison, WI 53706. Copyright 1994 by the State Medical Society of Wisconsin.

Differing recommendations

Published recommendations for parenteral B_{12} replacement differ. Loading schedules range from as low as 100 μg weekly[5] to 1000 μg per day.[6] Maintenance dosages range from 100 μg to 1000 μg monthly.[7,8] Several texts state that the selection of a replacement schedule is arbitrary.[9,10] Most treatment schedules recommend more intensive therapy if neurological disease is present, although little evidence is offered to support this. Parenteral, rather than oral, regimens are generally recommended.[9,10]

One reason for the varying recommendations on dosage is the availability of different cobalamin preparations in different countries. Hydroxocobalamin is used in the United Kingdom, while in the United States the only commercially available preparation is cyanocobalamin. Hydroxocobalamin is better bound to serum proteins and is less rapidly excreted. Therefore, comparatively lower dosages or less frequent injections may be appropriate with hydroxocobalamin.[11] The remainder of this discussion concerns cyanocobalamin, the sole B_{12} preparation in the United States.

How much is enough?

A reasonable goal of parenteral therapy is to optimize and maintain B_{12} stores with the fewest injections and at the lowest cost. Although loading schedules differ among different sources, there is a unanimity of opinion that a loading schedule should be used.

How much vitamin B_{12} should be used for loading? One recommendation includes a daily series of 14 injections of 100 μg, followed by 1000 μg intramuscularly each month for maintenance.[12] If one objective in treatment is using the fewest injections to optimize stores, there is little basis for using doses of 100 μg per injection. Although with larger doses of vitamin B_{12}, the bulk of the vitamin is excreted in the urine, there is also a much greater amount of cobalamin retained. For example, from a 100 μg injection, an average of 45% (45 μg) is lost in the urine, for a retention of 55 μg. From a 1000 μg dose, 850 μg may be lost in the urine, but 150 μg would be retained.[13]

Thus, a series of 14 injections of 100 μg would be roughly equivalent (in terms of cobalamin retained) to 5 or 6 biweekly injections of 1000 μg.[14]

For maintenance therapy, different lines of evidence have been used to arrive at different recommendations for the amount of cobalamin needed to maintain stores.

A radioisotopic study of B_{12} excretion calculated a rate of physiological loss of 1.2 μg/day, with average total stores measured at 3.03 mg.[15] A different study of radioisotopic excretion found that the rate of loss of cobalamin varied with body stores. With the rate of loss determined to be 0.15% to 0.20% of stores, the cobalamin requirement was estimated at 1.5 to 10.0 μg/day to maintain body stores of 1.0 to 5.0 mg.[16]

Another approach to determining optimal maintenance therapy has been to measure serum levels of cobalamin after injection of different dosages and preparations. One study of 26 patients with pernicious anemia in relapse found that a single dose of 1000 μg cyanocobalamin maintained serum levels above 200 pg/mL for an average of 3.2 weeks, with a range of 1 to 6 weeks.[17] Thereafter, monthly dosing of 1000 μg, 500 μg, or 250 μg cyanocobalamin appeared to maintain adequate serum levels in most patients. There was substantial inter-individual variability, however, and serum B_{12} levels fell below 200 pg/mL in some instances when lower doses were used.[17] Other studies have confirmed the wide inter-individual variability in B_{12} levels following injections of the vitamin.[11]

A retrospective analysis of patients with pernicious anemia who discontinued cobalamin injections found a wide variability in the time to relapse.[18] Macrocytosis occurred an average of 49.2 months, and diagnosis at 64.5 months (range 21 to 123 months) from cessation of treatment. The authors suggest that monthly B_{12} injections may be needlessly frequent.

Heterogeneity of B_{12} deficiency

One problem in estimating the requirement for B_{12} in a particular individual is the heterogeneity of B_{12} deficiency. For example, malabsorption of food cobalamin may occur in many patients with low serum B_{12} levels who may also have normal absorption of aqueous cyanocobalamin.[19] In other patients with documented pernicious anemia, cobalamin levels may be only slightly or moderately low.[20] These differences in B_{12} levels among patients may relate to the different phases of nutrient deficiency in which patients are diagnosed. After a period of negative nutrient balance, biochemical deficits due to nutrient deficiency may be detectable. Later, clinical signs of deficiency may be evident.[21]

The importance of early recognition of B_{12} deficiency was emphasized in a study showing time dependency of cognitive recovery with cobalamin replacements. Cobalamin deficient patients whose cognitive impairment had been present less than 12 months showed significant improvement with treatment; patients whose symptoms had been present greater than 12 months did not improve.[22]

Oral therapy

Some consider oral replacement therapy an equally efficacious alternative to parenteral cobalamin. About 1% of cyanocobalamin is absorbed orally without intrinsic factor, probably via a mass action or diffusion effect.[23] Waife et al found that oral cobalamin in a dosage of 300 μg/day corrected subnormal levels and yielded B_{12} absorption of about 3 μg/day.[23] Oral therapy with 1000 μg daily cobalamin is considered equivalent to intermittent injections in Sweden,[24] and is currently used in 40% of Swedish patients requiring cobalamin. A study of 21 Swedish patients--some on long-term oral, some on parenteral, cobalamin regimens--found comparable body stores in each group.[24]

It has been cautioned, however, that patients on oral therapy should be diagnosed, treated, and monitored by a physician.[25] This opinion largely reflects the conventional concern among US physicians that patients may not maintain long-term compliance with B_{12} therapy. Long-term compliance with oral cobalamin, however, is similar to that with periodic injections where oral therapy is used extensively.[24] Lapses of compliance with periodic B_{12} injections are well documented.[18]

Cost and toxicity

Vitamin B_{12} is inexpensive. In Madison, Wis, the 1000 μg dose of parenteral cyanocobalamin is available more cheaply than the 100 μg dose: 31.2 cents to 37.5 cents compared with 49.4 to 55.9 cents per unit. This is primarily because of the availability of a generic version of the 1000 μg/mL preparation. Oral vitamin B_{12} is available at $4.49 per 100 for a 500 μg pill, or $5.50 per 100 of a 1000 μg sublingual version. Clearly, the cost of the drug itself is not a primary consideration, and most of the costs for parenteral therapy would be reflected in clinic and professional fees. Clinic fees, including pharmacy charges, are roughly $20 to $25 per injection, while a home nursing visit would be $90 for the professional charges alone.[26]

Toxicity of cobalamin in humans has not been reported. The cobalt and cyanide contained in 1000 μg consumed daily are toxicologically insignificant.[25]

Conclusions

Widely differing recommendations are published for vitamin B_{12} replacement therapy. Loading with vitamin B_{12} can be reasonably accomplished with 5 or 6 biweekly injections of cyanocobalamin. Thereafter, maintenance with 1000 μg per month provides sufficient amounts of B_{12} to meet metabolic needs, avoid subnormal levels, and maintain stores. Parenteral dosages of 100 μg offers no therapeutic or cost advantages.

Oral therapy may be an effective alternative to parenteral therapy for many patients, and has the advantage of obviating need for clinic or home health visits. This form of therapy should be initiated and monitored by physicians, and should include periodic monitoring to ensure compliance and therapeutic response.

Acknowledgement
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A call for papers

Gun violence
SMS President Richard Roberts, MD, JD, hopes to help physicians fight the rise of death and injury from gun violence in Wisconsin during his term as president (1994-1995). In coordination with that campaign, the *Wisconsin Medical Journal* is seeking articles from Wisconsin physicians on the subject of gun violence, exploring its nature, causes, costs, effects and possible solutions. Scientific, socioeconomic and organizational papers, as well as letters, are sought for a special issue.

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The *WMJ* is also seeking articles on providing health care to Wisconsin's minority communities. If you are serving a significant minority patient base, or are studying the delivery of health care to minority populations, please consider submitting a paper on your findings to the *WMJ* for possible publication in a special issue.

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Where have our creative writers gone? Share your personal experiences of special significance, your poetry or your short stories with your colleagues through the *WMJ*s "Soundings" feature. Of course, your "Soundings" should be related, in some way, to your being a physician.

Authors guidelines
Guidelines for writers are available from *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701; or by calling 257-6781 (Madison area) or 800-362-9080.❖

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Trends in the stage of cancer at the time of diagnosis

Philip N. Redlich, MD, PhD; Timothy L. McAuliffe, PhD; Lisa A. Robinson, RRA; and Kathy L. Reith, RRA, CTR, Milwaukee

The stage of cancers at the time of diagnosis for 10 major sites of disease from patients treated at two Medical College of Wisconsin teaching hospitals was analyzed from tumor registry data and compared from the years 1983, 1987, and 1991. A trend toward earlier stages of cancer of major sites was noted, with patients having in situ or localized disease increasing from 35% in 1983 to 48% in 1991. Patients with breast cancer demonstrated the strongest trend, with 44% of the cases representing in situ or localized disease in 1983 compared to 61% in 1991 (p=0.03). A shift toward earlier stage of cancer at diagnosis was also noted for other major sites including: lung, trachea and bronchus; colon and rectum; and prostate cancers. Trends toward an earlier stage of cancer may result from patient and physician education, local practice patterns, as well as proper use of screening programs. Information on such trends from hospital tumor registries may be helpful in the appropriate and efficient allocation of local health care resources. *Wis Med J.1994;93(5):207-212.*

The success of treatment of malignant disease is related to the extent of disease, or stage, at the time of diagnosis. Much emphasis has been placed on methods to detect cancer at earlier stages of disease to improve cure rates. Widespread use of screening programs, such as physical breast examination with mammography for breast cancer and digital rectal examination with prostate-specific antigen (PSA) testing for prostate cancer, have been suggested as tools to accomplish reductions in cancer mortality.[1,2] The effectiveness of such screening programs are reflected by trends in the stage of disease at the time of diagnosis as well as mortality.

National data regarding such trends are available from the National Cancer Data Base, but national trends may not accurately reflect local experience. We undertook an analysis of trends in the stage of disease at diagnosis of 10 major cancer sites from two Medical College of Wisconsin teaching hospitals: John L. Doyne (formerly Milwaukee County Medical Complex) and Froedtert Memorial Lutheran Hospitals.

From the departments of surgery and biostatistics at the Medical College of Wisconsin in Milwaukee, and the tumor registry at John L. Doyne Hospital in Milwaukee. Reprint request to: Philip N. Redlich, MD, PhD, Department of General Surgery, Medical College of Wisconsin, 9200 W Wisconsin Ave, Milwaukee, WI 53226. Copyright 1994 by the State Medical Society of Wisconsin.

Methods

The tumor registry serving both John L. Doyne and Froedtert Memorial Lutheran Hospitals was the source of data for this study. Although the registry has been collecting data since 1955, data from 1983 are computerized and available through the CANSUR/NET software system. Data from the 10 major cancer sites from the years 1983, 1987, and 1991 were analyzed.

Stage of disease was categorized according to the General Summary Staging System.[3] In addition, all breast cancer cases were re-staged according to the staging criteria of the American Joint Committee on Cancer (AJCC).[4] Only new analytical cancer cases were analyzed, ie, patients who were diagnosed with cancer or received all or part of their initial treatment at either of the two hospitals. The Cochran-Mantel-Haenszel statistics were used to test for trends in extent of disease.

Results

The number of cases in the registry increased from 824 in 1983 and 851 in 1987 to 975 in 1991. The 10 primary cancer sites along with the number of cases of each site are presented in Table 1. Cases from the 10 sites represent 64%, 65%, and 75% of the cases in 1983, 1987 and 1991, respectively. Nearly all sites in 1991 had an increase in the number of cases from earlier years, with prostate and breast cancer cases experiencing the greatest increase from 1983 through 1991.

An analysis of the stage of disease, by General Summary Stage, at diagnosis was undertaken to evaluate for any trends for the 10 major cancer sites (Figure). The percentage of new cases having in situ or localized disease increased significantly from 35% in 1983 to 48% in 1987 and 1991 ($p<0.001$). Among the major sites, breast cancer showed the strongest evidence of a trend toward earlier stage at diagnosis, with 44% of the cases representing in situ or localized disease in 1983 compared to 61% in 1991 ($p<0.05$). Additionally, the percentage of breast cancer cases with distant disease decreased from 15% to 9% over the same period.

Other major sites in which trends were observed included: lung, trachea and bronchus cancers; colon and rectum cancers; and prostate cancers. A shift toward earlier stage at diagnosis of lung, trachea and bronchus cancers was observed between 1983 and 1987, stabilizing thereafter ($p<0.05$). The percentage

of colon and rectum cancers with in situ or localized disease at diagnosis rose significantly from 26% in 1983 to 44% in 1991 ($p<0.05$). Though the number of prostate cancers doubled from 1983 through 1991, the percentage with distant disease decreased from 18% in 1983 to 8% in 1991.

A more detailed analysis of female breast cancer cases was performed for the same period. The age distribution of patients with newly diagnosed breast cancer was similar in 1983, 1987, and 1991, with 40% to 50% of patients between the ages of 50 and 69. Few patients were less than age 40 or greater than 80. The patients of black and other non-white races represented 20% of the cases in 1991, compared to 14% in 1983 and 6% in 1987.

Analysis of breast cancer cases by AJCC staging criteria showed a trend toward earlier stages of disease, as noted above, with the percentage of cases with stage 0 or I increasing from 28% in 1983 to 44% in 1991 (Table 2). Indeed, the increase in the number of patients with stage 0 or I disease represented 70% of the increased number of breast cases from 1983 through 1991. The percentage of patients with node-positive disease decreased from 40% in 1983 to 32% in 1991, while the percentage with unknown node involvement remained approximately 23%. AJCC stage of disease was associated with race (not shown), blacks and other non-white races more frequently having later stages of disease at diagnosis ($p=0.03$), but did not correlate with patient age.

Discussion

Analysis of hospital tumor registry data has revealed significant trends in the stage of cancer in patients at two Medical College of Wisconsin teaching hospitals. Our analysis has documented a trend toward earlier stages of disease for major sites of cancer including cancers of the: breast; lung, trachea and bronchus; colon and rectum; and prostate. Other reports have documented such trends in cancer, particularly breast cancer, attributing the increased percentage of early stage disease to the increased usage of mammography in Wisconsin.[5-8]

Other screening methods likely to influence stage of cancers at diagnosis include PSA testing for prostate cancer and sigmoidoscopy for colorectal cancer, the latter having been shown to decrease colorectal cancer mortality.[2,9,10] Interestingly, a trend toward earlier stage of lung,

Continued on page 211

Table 1.--New cancer cases of major sites.

Primary site	1983		1987		1991	
	No.	*%*	*No.*	*%*	*No.*	*%*
Lung, trachea and bronchus	107	13.0	105	12.3	132	13.5
Breast (female)	72	8.7	109	12.8	116	11.9
Prostate	55	6.7	43	5.1	110	11.3*
Colon and rectum	69	8.4	59	6.9	66	6.8
Lymphoma	35	4.2	36	4.2	66	6.8
Eye, brain and nervous system+	40	4.9	52	6.1	55	5.6
Oral cavity and pharynx	47	5.7	35	4.1	55	5.6
Kidney, bladder and other urinary	35	4.2	45	5.3	52	5.3
Blood and bone marrow	38	4.6	30	3.5	39	4.0
Cervix uteri	29	3.5	42	4.9	36	3.7
Other sites	297	36.0	295	34.7	248	25.4
Totals	824		851		975	

*Increase in prostate cancer compared to both 1987 and 1983 ($p<0.001$).
+Includes nine, 19 and 20 eye cancers in 1983, 1987 and 1991, respectively.

Table 2.--New female breast cancer cases by AJCC stage.

Stage	1983		1987		1991	
	No.	*%*	*No.*	*%*	*No.*	*%*
0	2	3	12	11	12	10
I	18	25	39	36	39	34
II	33	46	31	28	46	40
III	8	11	17	16	9	8
IV	11	15	10	9	10	9
Total	72		109		116	

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  CLARITIN Tablets started working in some patients in as soon as 30 minutes; 65% of patients experienced relief within 2 hours.[1]

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  In controlled clinical trials using the recommended dose, the incidence of headache (12%), somnolence (8%), fatigue (4%), and dry mouth (3%) with CLARITIN Tablets was similar to that of placebo (11%, 6%, 3%, and 2%, respectively).

- **Over 1 billion patient days of worldwide experience**

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Once-a-day

Claritin®

10 mg TABLETS (loratadine)

* In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.

† Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes (P=.04). At 2 hours, 48% of patients receiving placebo experienced relief. Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo (P=.03).

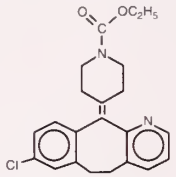
Please see following page for brief summary of Prescribing Information.

CLARITIN®
brand of loratadine
TABLETS
Long-Acting Antihistamine

PRODUCT INFORMATION

DESCRIPTION CLARITIN Tablets contain 10 mg micronized loratadine, an antihistamine, to be administered orally. They also contain the following inactive ingredients: corn starch, lactose, and magnesium stearate.

Loratadine is a white to off-white powder not soluble in water, but very soluble in acetone, alcohol, and chloroform. It has a molecular weight of 382.89, and empirical formula of $C_{22}H_{23}ClN_2O_2$; its chemical name is ethyl 4-(8-chloro-5,6-dihydro-11*H*-benzo[5,6]cyclohepta[1,2-*b*]pyridin-11-ylidene)-1-piperidinecarboxylate and has the following structural formula:



CLINICAL PHARMACOLOGY Loratadine is a long-acting tricyclic antihistamine with selective peripheral histamine H_1-receptor antagonistic activity.

Human histamine skin wheal studies following single and repeated 10 mg oral doses of CLARITIN Tablets have shown that the drug exhibits an antihistaminic effect beginning within 1 to 3 hours, reaching a maximum at 8 to 12 hours and lasting in excess of 24 hours. There was no evidence of tolerance to this effect after 28 days of dosing with CLARITIN Tablets.

Pharmacokinetic studies following single and multiple oral doses of loratadine in 115 volunteers showed that loratadine is rapidly absorbed and extensively metabolized to an active metabolite (descarboethoxyloratadine). The specific enzyme systems responsible for metabolism have not been identified. Approximately 80% of the total dose administered can be found equally distributed between urine and feces in the form of metabolic products after 10 days. The mean elimination half-lives found in studies in normal adult subjects (n = 54) were 8.4 hours (range = 3 to 20 hours) for loratadine and 28 hours (range = 8.8 to 92 hours) for the major active metabolite (descarboethoxyloratadine). In nearly all patients, exposure (AUC) to the metabolite is greater than exposure to parent loratadine.

In a study involving twelve healthy geriatric subjects (66 to 78 years old), the AUC and peak plasma levels (Cmax) of both loratadine and descarboethoxyloratadine were significantly higher (approximately 50% increased) than in studies of younger subjects. The mean elimination half-lives for the elderly subjects were 18.2 hours (range = 6.7 to 37 hours) for loratadine and 17.5 hours (range = 11 to 38 hours) for the active metabolite.

Loratadine, dosed once daily, had reached steady-state by the fifth daily dose. The pharmacokinetics of loratadine and descarboethoxyloratadine are dose independent over the dose range of 10 to 40 mg and are not significantly altered by the duration of treatment.

In the clinical efficacy studies, CLARITIN Tablets were administered before meals. In a single-dose study, food increased the AUC of loratadine by approximately 40% and of descarboethoxyloratadine by approximately 15%. The time to peak plasma concentration (Tmax) of loratadine and descarboethoxyloratadine was delayed by 1 hour with a meal. Although these differences would not be expected to be clinically important, CLARITIN Tablets should be administered on an empty stomach.

In patients with chronic renal impairment (Creatinine Clearance ≤ 30 mL/min) both the AUC and peak plasma levels (Cmax) increased on average by approximately 73% for loratadine; and approximately by 120% for descarboethoxyloratadine, compared to individuals with normal renal function. The mean elimination half-lives of loratadine (7.6 hours) and descarboethoxyloratadine (23.9 hours) were not significantly different from that observed in normal subjects. Hemodialysis does not have an effect on the pharmacokinetics of loratadine or its active metabolite (descarboethoxyloratadine) in subjects with chronic renal impairment.

In patients with chronic alcoholic liver disease the AUC and peak plasma levels (Cmax) of loratadine were double while the pharmacokinetic profile of the active metabolite (descarboethoxyloratadine) was not significantly changed from that in normals. The elimination half-lives for loratadine and descarboethoxyloratadine were 24 hours and 37 hours, respectively, and increased with increasing severity of liver disease.

There was considerable variability in the pharmacokinetic data in all studies of CLARITIN Tablets, probably due to the extensive first-pass metabolism. Individual histograms of area under the curve, clearance, and volume of distribution showed a log normal distribution with a 25-fold range in distribution in healthy subjects.

Loratadine is about 97% bound to plasma proteins at the expected concentrations (2.5 to 100 ng/mL) after a therapeutic dose. Loratadine does not affect the plasma protein binding of warfarin and digoxin. The metabolite descarboethoxyloratadine is 73% to 77% bound to plasma proteins (at 0.5 to 100 ng/mL).

Whole body autoradiographic studies in rats and monkeys, radiolabeled tissue distribution studies in mice and rats, and *in vivo* radioligand studies in mice have shown that neither loratadine nor its metabolites readily cross the blood-brain barrier. Radioligand binding studies with guinea pig pulmonary and brain H_1-receptors indicate that there was preferential binding to peripheral versus central nervous system H_1-receptors.

Clinical trials of CLARITIN Tablets involved over 10,700 patients who received either CLARITIN Tablets or another antihistamine and/or placebo in double-blind randomized controlled studies. In placebo-controlled trials, 10 mg once daily of CLARITIN Tablets was superior to placebo and similar to clemastine (1 mg BID) or terfenadine (60 mg BID) in effects on nasal and non-nasal symptoms of allergic rhinitis. In these studies, somnolence occurred less frequently with CLARITIN Tablets than with clemastine and at about the same frequency as terfenadine or placebo. In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed. Therefore, some patients, particularly those with hepatic or renal impairment and the elderly, may experience somnolence.

In a study in which CLARITIN Tablets were administered at 4 times the clinical dose for 90 days, no clinically significant increase in the QTc was seen on ECGs.

INDICATIONS AND USAGE CLARITIN Tablets are indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

CONTRAINDICATIONS CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIONS **General:** Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite, descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the QTc on ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole.

Other drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS

PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Dry Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adverse events have been reported in 2% or fewer patients.

Autonomic Nervous System Altered salivation, increased sweating, altered lacrimation, hypoesthesia, impotence, thirst, flushing.

Body As A Whole Conjunctivitis, blurred vision, earache, eye pain, tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pain, rigors, fever, aggravated allergy, upper respiratory infection, angioneurotic edema.

Cardiovascular System Hypotension, hypertension, palpitations, syncope, tachycardia.

Central and Peripheral Nervous System Hyperkinesia, blepharospasm, paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.

Gastrointestinal System Abdominal distress, nausea, vomiting, flatulence, gastritis, constipation, diarrhea, altered taste, increased appetite, anorexia, dyspepsia, stomatitis, toothache.

Musculoskeletal System Arthralgia, myalgia.

Psychiatric Anxiety, depression, agitation, insomnia, paroniria, amnesia, impaired concentration, confusion, decreased libido, nervousness.

Reproductive System Breast pain, menorrhagia, dysmenorrhea, vaginitis.

Respiratory System Nasal dryness, epistaxis, pharyngitis, dyspnea, nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bronchospasm, bronchitis, laryngitis.

Skin and Appendages Dermatitis, dry hair, dry skin, urticaria, rash, pruritus, photosensitivity reaction, purpura.

Urinary System Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratadine: peripheral edema; abnormal hepatic function, including jaundice, hepatitis, and hepatic necrosis; alopecia, seizures; breast enlargement; erythema multiforme; and anaphylaxis.

DRUG ABUSE AND DEPENDENCE There is no information to indicate that abuse or dependency occurs with CLARITIN Tablets.

OVERDOSAGE Somnolence, tachycardia, and headache have been reported with overdoses greater than 10 mg (40 to 180 mg). In the event of overdosage, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdosage would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid dilution of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

Oral LD_{50} values for loratadine were greater than 5000 mg/kg in rats and mice. Doses as high as 10 times the recommended clinical doses showed no effects in rats, mice, and monkeys.

DOSAGE AND ADMINISTRATION Adults and children 12 years of age and over: One 10 mg tablet daily on an empty stomach.

In patients with liver failure, 10 mg every other day should be the starting dose.

HOW SUPPLIED CLARITIN Tablets, 10 mg, white to off-white compressed tablets; impressed with the product identification number "458" on one side; and "CLARITIN 10" on the other; high density polyethylene plastic bottles of 100 (NDC 0085-0458-03). Also available, CLARITIN Unit-of-Use packages of 14 tablets (7 tablets per blister card) (NDC 0085-0458-01) and 30 tablets (10 tablets per blister card) (NDC 0085-0458-05); and 10 x 10 tablet Unit Dose-Hospital Pack (NDC 0085-0458-04).

Protect Unit-of-Use packaging and Unit Dose-Hospital Pack from excessive moisture. Store between 2° and 30°C (36° and 86°F).

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Continued from page 208
trachea and bronchus cancers was noted in our analysis, but no screening program currently exists for such tumors.

A more detailed analysis of breast cancer cases revealed an overall increase in the number of black or other patients of non-white races. These patients more frequently had later stages of disease at diagnosis, a correlation similarly noted in other studies.[11] The apparent association between race and stage may, however, more properly reflect a correlation between socioeconomic status, rather than race, and stage of disease, as has been suggested by others.[12]

The trends in stage of cancer in our data correlate well with those of Wisconsin, but not as well with national trends. For example, a trend toward earlier stage for colon and rectum cancers was noted for both our data and that of Wisconsin, but not for national data as reported in the National Cancer Data Base.[13,14] Therefore, analyses of local and regional data rather than national data may better reflect local patient and physician education programs as well as local practice patterns, including the use and effectiveness of screening programs.

Knowledge of changing patterns of cancer stage of patients treated at a health care facility may allow that facility to adapt more readily to patient care requirements. Hospitals that operate a tumor registry may find, as we have demonstrated in our report, that their registry is an important resource for such information. For example, the trend toward earlier stage of breast cancer, often first seen as nonpalpable tumors, mandates changes in diagnostic procedures from a standard open biopsy technique used for palpable lesions to mammographic- or ultrasound-guided biopsies. Therefore, a more appropriate and efficient use of local hospital resources for cancer care may result from changes implemented following review of tumor registry data.

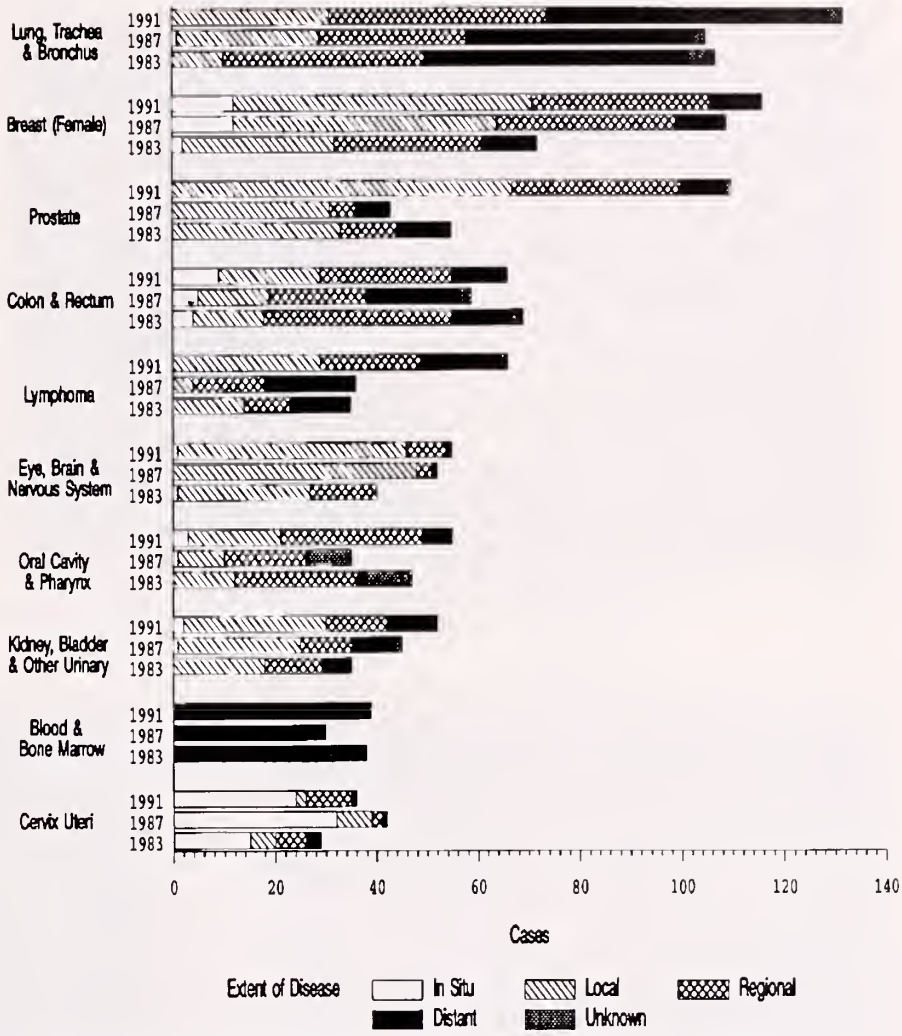

Fig.—Stage of cancer of major sites. The extent of disease of patients as staged by the General Summary Staging System is presented for the 10 major sites of cancer. The length of the bar represents the total number of cases of cancer per year for each site. The stage of disease is represented by the differently shaded sections of the bar in proportion to the number of respective cases.

Acknowlegements

The figure and tables have been modified from those originally presented in the *1991 John L. Doyne Cancer Program Annual Report*. Permission to use the figure and tables has been granted by Doyne Hospital.

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Unusual complication of coumadin toxicity

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Coumadin is a coumarin anticoagulant that induces a state similar to vitamin K deficiency and is routinely used for chronic oral anticoagulation. Intramural hematoma of the bowel is a rare complication of anticoagulant therapy. In this paper, we describe such a case of an anticoagulated patient who had complaints of abdominal pain and who had inadvertently been taking higher dose of coumadin. Although the diagnosis can usually be made by history and plain abdominal x-ray, we report here some radiographic signs that can be seen on a CT-scan of the abdomen and are relatively specific for this diagnosis. We stress the importance of recognizing the disorder because the management is conservative and surgery is reserved for cases in which no improvement is seen. *Wis Med J.1994;93(5):212-214.*

Coumadin is a coumarin anticoagulant that interferes with hepatic vitamin K dependent carboxylation of factors II, VII, IX, and X the anticoagulant proteins C and S.[1] Oral anticoagulants are commonly used in patients who have pulmonary embolism, deep venous thrombosis, prosthetic heart valves, or persistent atrial fibrillation.[2] Although the most common complication of coumadin toxicity is bleeding, other rare causes include necrosis of the skin, alopecia, "purple toes" secondary to systemic cholesterol embolization, and intramural hematoma resulting in either partial or total small bowel obstruction.[2] Because of the increasing frequency of coumadin use and the implications for the primary care physician, we discuss the etiology, clinical signs, diagnosis, and management of intramural hematoma.

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Case report

A 59-year-old woman, complaining about abdominal pain, nausea, and vomiting was brought to the emergency room. Her abdominal pain was located in the left upper quadrant and in the epigastric region. The pain was described as being constant and was not affected by eating. She had six episodes of emesis prior to her admission and an episode of hematemesis in the emergency room.

The patient's medical history was significant for recurrent pulmonary emboli. For this condition the patient had been advised to take 5 mg of coumadin per day. This dose was therapeutic for her. She had, however, inadvertently been taking 10 mg per day for about 10 days prior to her admission. The patient had no history of peptic ulcer disease or surgeries. Her other medication included captopril and clonidine for hypertension.

The patient's vital signs on admission were a temperature of 99.8°, BP 170/100, respiratory rate of 20, and a pulse of 100. The physical examination was significant for a left subconjunctival hemorrhage. The cardiac examination revealed a palpable right ventricular heave and systolic murmur that was consistent

Fig 1.--A plain abdominal film at the time of admission revealing the "thick bowel sign."

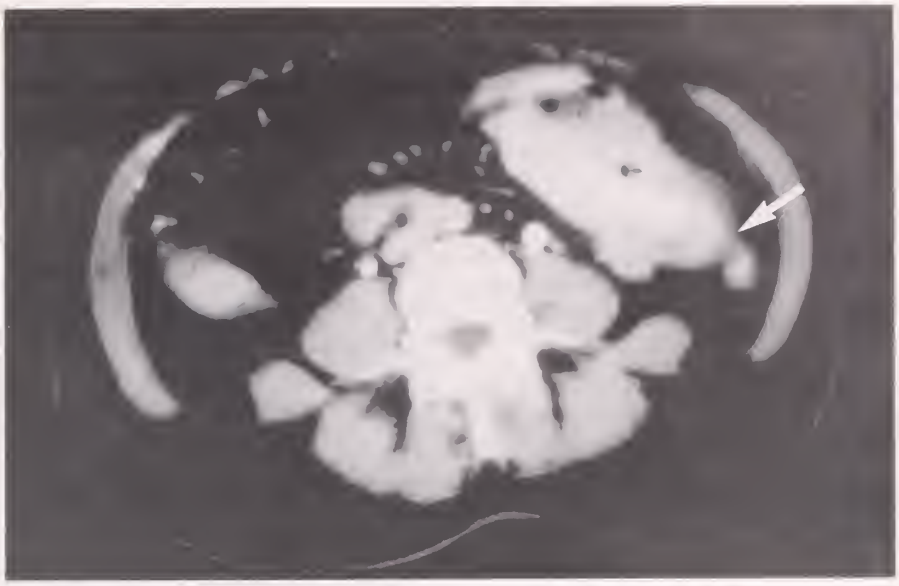

Fig 2.--CT scan of the abdomen showing the thickened bowel wall.

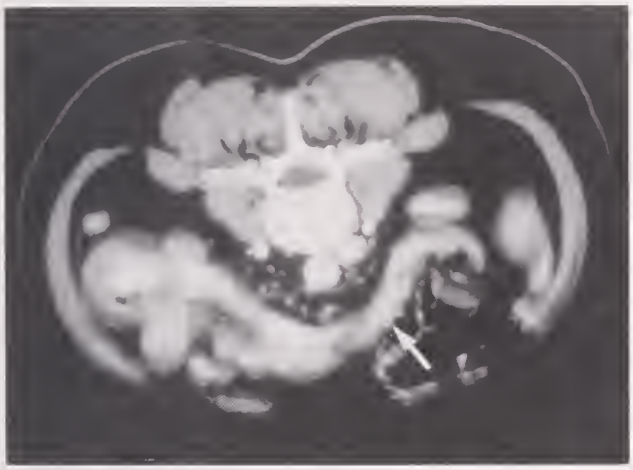

Fig 3.-- CT scan showing the "coiled spring sign."

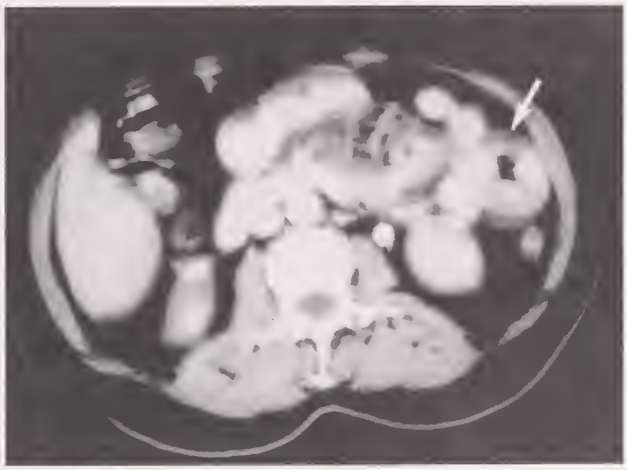

Fig 4.-- CT-scan at the level of the kidney showing the "pseudokidney sign."

with tricuspid insufficiency. The abdomen was soft, had hypoactive bowel sounds, and was tender in the left upper quadrant and epigastric region. There was no rebound tenderness noted. Significant laboratory data included a prothrombin time (PT) 50.2 seconds (NL 11.1-12.7 sec) and a lipase of 261u/dL (NL 45-200 u/dL).

An abdominal series was obtained and this revealed an abnormal loop of gas-filled proximal small bowel with thickened wall (Fig 1). A CT scan of the abdomen showed an abnormal thickening of the bowel wall of the proximal small intestine (Fig 2), a "coiled spring sign" (Fig 3), and a "pseudo kidney sign" (Fig 4). The liver, spleen, kidneys and adrenals were normal. The gallbladder contained multiple stones but there was no biliary dilatation.

The partial small bowel obstruction was conservatively managed with parenteral fluids, nasogastric decompression and careful observation. The anticoagulant effects of coumadin were reversed with infusion of fresh frozen plasma and vitamin K. The PT decreased to 21.8 seconds within 24 hours and to 14.7 seconds within 72 hours of admission. The patient's nausea, vomiting and abdominal pain resolved and she was started on a general diet. Abdominal x-rays were repeated and showed no evidence of small bowel obstruction. Coumadin was stopped and a Greenfield filter was placed in the inferior vena cava.

Discussion

Intramural hematomas of the small intestine are very rare with fewer than 300 cases reported.[4] The majority of these cases are due to abdominal trauma with anticoagula-

tion accounting for approximately 33% of the cases.[4] The incidence in men is fourfold higher than women.[4] The most common site of hemorrhage is localized to the duodenum and proximal jejunum. This is due to the fact that the duodenum is fixed on a shortened mesentery, has a double vascular plexus and the submucosa lacks a circumferential serosal layer.

The most common symptoms in these patients are nausea, vomiting, and abdominal pain, although 50% of the patients are initially asymptomatic.[4-6] Thirty percent of the patients have an associated gastrointestinal hemorrhage although major bleeding is rare.[4] On physical examination, there is usually marked diffuse tenderness of the abdomen with bowel sounds being present. Rigidity of the abdomen is rarely seen. Laboratory findings include leukocytosis in about 70% of the patients and anemia in 23%. Approximately 16% of the patients have an elevated amylase.[4]

The diagnosis of intramural hematoma is greatly aided with radiographic studies. A plain abdominal x-ray can demonstrate a pattern consistent with obstruction. Usually a "thick bowel sign" is seen which is demonstrated by the presence of gas in a greatly narrowed bowel lumen.[7] This sign is not pathognomonic for intramural hematoma and can be seen in tuberculosis, lymphoma, and regional enteritis involving the jejunum or ileum. A CT scan of the abdomen reveals two additional signs commonly seen in intramural hematoma. The first is the "coiled spring sign"[8] and the second is called a "pseudokidney sign" because of its resemblance to kidney on a CT scan.[3] Both of these signs are due to the infiltration of blood or edema into the valvulae conniventes resulting in their crowding distal to the hematoma.[7] While these signs are not pathognomonic, in the right clinical context they have high diagnostic accuracy. Another advantage of the CT scan is the ability to reveal any intraperitoneal bleeding.[9]

The treatment of intramural hematomas is conservative and involves reversing the clotting disorder with vitamin K and infusion of fresh frozen plasma. Patients are also given parenteral fluids and a nasogastric tube is used for decompression. Conservative treatment is continued for at least 7 days and if there is no improvement, surgery should be considered.[5] Surgery is usually indicated in cases where the viability of the bowel wall is questionable or patient has persistent worsening symptoms of obstruction.[5] The diagnosis of intramural hematoma is made with a noninvasive test such as the CT scan. This paper indicates the importance of recognizing intramural hematomas as a potential complication of coumadin toxicity since the primary treatment is medical and will save the patient unnecessary surgery.

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Public health

Regional differences in smoking rates among women giving birth in Wisconsin, 1990-1992

Darren Bush, MA; Susan Latton; Susan Uttech, MS, CHES; Richard Aronson, MD, and Patrick L. Remington, MD, MPH, Madison

Numerous studies have shown that smoking in pregnancy is harmful to the fetus.[1] In fact, a recent report suggests that smoking cigarettes may do more harm to the developing fetus than ingesting cocaine.[2] Maternal tobacco consumption has been demonstrated to lead to reductions in birth weight by 150 g to 250 g. Women who smoke during pregnancy also show significant increases in spontaneous abortion, complications involving the placenta, and pre-term delivery. This distress to both mother and fetus, combined with an economic cost of more than $60 million a year in Wisconsin alone, demonstrate the seriousness of maternal tobacco consumption.[3]

In 1989, the Wisconsin birth certificate was modified to include the smoking status of the mother. In this report, we analyzed these data for 1990 to 1992 by county. This information can be used to identify areas of the state with high rates of smoking in need of targeted programs.

Methods

The data were collected from the birth certificate database within the Wisconsin vital registration system. The question asked on the birth certificate was simply whether the mother smoked cigarettes during her pregnancy. Data were extracted for the years 1990 to 1992.

Results

Between 1990 and 1992, 22.4% of the 214,763 women who gave birth reported smoking cigarettes. The percent of women who smoke declined slightly from 22.9% in 1990 to 22.6% in 1991 and 21.7% in 1992. There is a strong relationship between region and smoking status during pregnancy (see table and figure). Northern counties show the highest percentages of pregnant women smokers, far above the state average of 22.4%. By contrast, southern counties show levels below the state average.

Discussion

These data demonstrate regional differences in smoking among women giving birth in Wisconsin. These differences may result from differences in the age and socioeconomic factors of women giving birth in these counties. For example, smoking rates are higher among women with lower education levels.[4] In addition, a previous study published in the *Wisconsin Medical Journal* showed that smoking rates were higher among younger women (31% of women ages 18-24 years were smokers compared to 15% of women ages 35-44).[3]

Data from the Wisconsin Behavioral Risk Factor Telephone Surveys have shown that smoking rates are higher in the northern, northeastern, and southeastern parts of the state (28%, 29%, and 28% respectively) (Wisconsin Division of Health, unpublished data). In contrast, smoking rates in the southern and western regions are lower (26% and 20% respectively). Thus, the higher smoking rates among women in the northern part of the state may reflect higher overall smoking rates in the general population in these

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Continued from preceding page
counties.

Reducing smoking rates among women of reproductive age will not be easy. Women continue to be a primary target of tobacco advertising, and while smoking rates in most populations are declining, the rate among women of reproductive age is not. One recent study showed an increase in the smoking initiation rate in women under 18 following the launching of an advertising campaign directed specifically at young women. This rate increase was particularly marked in women of this age group who had never attended college.[5]

Physicians and other health care providers should use the many opportunities that routine prenatal care affords, to assist women in their efforts to quit smoking. For low-income women, prenatal care coordination is now a reimbursable Medical Assistance benefit, providing pregnant women access to 115 certified prenatal care coordination providers in 66 counties across Wisconsin. In addition, regional seminars are being held this month throughout the state to support smoking cessation skills among prenatal care providers.

The Public Health Agenda for Wisconsin has establish an objective for the year 2000 to reduce the smoking rate among pregnant women to 10%. Currently, no county has a smoking rate lower than 10%. Assuming that the smoking rate continues to decline as it did from 1990 to 1992, the smoking rate would be about 17% by the year 2000. If Wisconsin is to meet the objective of 10%, greater attention needs to be directed toward helping women who are pregnant quit smoking.

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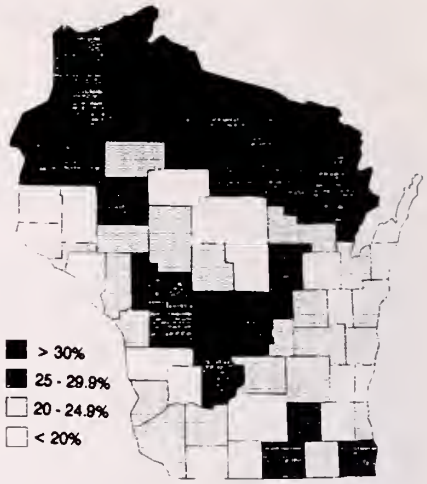

Percent of women giving birth who reported smoking during pregnancy in Wisconsin, 1990-1992.

County	Total Births	Percent Smokers	Rank	County	Total Births	Percent Smokers	Rank
Adams	526	36%	4	Marathon	5,000	17%	68
Ashland	600	33%	9	Marinette	1,367	27%	21
Barron	1,684	25%	31	Marquette	422	29%	14
Bayfield	484	32%	10	Menominee	371	45%	1
Brown	9,251	22%	43	Milwaukee	50,218	25%	34
Buffalo	500	17%	66	Monroe	1,723	28%	19
Burnett	441	34%	8	Oconto	1,172	27%	23
Calumet	1,492	17%	67	Oneida	1,112	26%	26
Chippewa	2,090	25%	30	Outagamie	6,756	15%	71
Clark	1,298	20%	53	Ozaukee	2,859	13%	73
Columbia	1,798	24%	36	Pepin	270	21%	51
Crawford	639	23%	38	Pierce	1,276	19%	61
Dane	15,730	16%	69	Polk	1,437	28%	18
Dodge	2,917	22%	45	Portage	2,567	18%	64
Door	945	20%	57	Price	567	25%	29
Douglas	1,473	29%	13	Racine	8,074	26%	27
Dunn	1,263	20%	55	Richland	633	20%	56
Eau Claire	3,527	21%	50	Rock	6,424	29%	17
Florence	127	34%	7	Rusk	599	25%	33
Fond du Lac	3,708	22%	47	Sauk	1,929	25%	28
Forest	402	35%	5	Sawyer	536	42%	2
Grant	1,860	24%	37	Shawano	1,486	22%	46
Green	1,253	20%	58	Sheboygan	4,112	21%	48
Green Lake	655	20%	52	St Croix	2,428	18%	63
Iowa	899	20%	54	Taylor	795	19%	60
Iron	186	34%	6	Trempeleau	1,092	25%	35
Jackson	651	29%	15	Vernon	971	19%	59
Jefferson	2,566	25%	32	Vilas	613	37%	3
Juneau	889	31%	11	Walworth	2,908	23%	39
Kenosha	6,331	29%	16	Washburn	460	26%	24
Kewaunee	681	16%	70	Washington	4,163	18%	62
La Crosse	4,202	21%	49	Waukesha	12,123	15%	72
Lafayette	680	17%	65	Waupaca	1,968	27%	22
Langlade	739	30%	12	Waushara	721	28%	20
Lincoln	1,033	26%	25	Winnebago	5,799	22%	44
Manitowoc	3,137	23%	41	Wood	3,130	23%	40

Wisconsin peer review
The health care quality improvement program

Jay A. Gold, MD, JD, and Barbara D. Heuer, RN, Madison

STARTING IN 1993, a nationwide shift has taken place in peer review. The health care quality improvement program (HCQIP) constitutes a new model for quality oversight of clinical decisionmaking.[1]

Peer review, as it has been conducted by PSROs and PROs since the 1970s, essentially has followed what might be called a "traffic-cop" model. Just as a traffic cop will pull a speeding driver over and give him a ticket, peer review organizations looked for medical actions that failed to measure up to an adequate level, and meted out such sanctions as were felt appropriate.

In 1990, the Institute of Medicine issued a report on medical peer review.[2] The institute found two problems with the traditional approach to peer review. First, there was no evidence that health care as a whole was being improved by the process--that is, that better medicine was being practiced than would have been the case without the program. Second, the medical community had developed enormous distrust, and occasionally outright hostility, toward peer review organizations and the peer review process.

The institute recommended that a new approach be adopted, an approach in which peer review would implement the principles of continuous quality improvement (CQI) associated in the industrial sphere with the work of W. Edwards Deming.[3] (These principles also have been called total quality management [TQM] and industrial quality management science [IQMS].) This recommendation was adopted by the Department of Health and Human Services.

HCQIP--which embodies the recommendation--was promulgated by the Health Care Financing Administration and implemented by all peer review organizations in 1993.

Principles of HCQIP

The principles of continuous quality improvement, on which HCQIP is based, include the following:

- *Consensus.* In general, this is established in medicine by the existence of accepted clinical standards.
- *Cooperation.* WIPRO will work cooperatively with both the medical community and the federal government to improve care.
- *Team approach.*
- *Physician involvement.* This is essential if care is to be improved, as it is the physician who renders that care.
- *Pattern identification.* Studies will be done to determine patterns of care and discover variations.
- *Benchmarking.* Facilities whose practice is significantly above the norm will be identified, and other facilities will be encouraged to move in that direction.
- *Improvement of care.*

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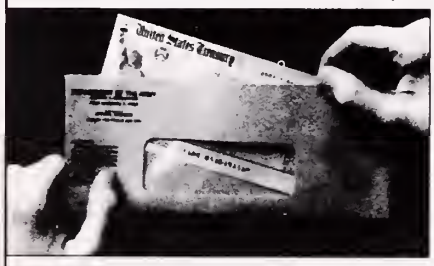

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Medical review under HCQIP

Medical peer review, along with statistical analysis, will be used to identify patterns of care and outcomes. With few exceptions, HCFA will select records for PRO case review. These selections will produce a national review level equal to about 12% of all Medicare inpatient hospital discharges and 5% of all claims specified for ambulatory surgery review. The 12% inpatient hospital category consists of the following:

- 4% Cooperative Cardiovascular Project (CCP);
- 5% random sample of beneficiaries;
- 1% equalization sample; and,
- 2% primary data collection.

Under HCFA's random sample selection, WIPRO will review all care provided to each beneficiary. For the equalization sample, HCFA will select a sample of inpatient hospital discharges to ensure a significant number of sampled cases (at least 50) for hospitals with limited discharges.

Other review areas where WIPRO is required to do 100% review are:

- assistants for cataract surgery;
- referrals from Medicare part A or part B or HCFA;
- beneficiary complaints;
- hospital-issued notices of non-coverage (HINN); and,
- requests for higher-weighted DRG adjustments.

The required review activities for the beneficiary-specific and equalization samples include: admission, quality, discharge, invasive procedure, DRG validation, coverage, and documentation review.

To facilitate improved reliability and consistency, medical review will be using an integrated format to document quality, use and DRG concerns. This will enable WIPRO and HCFA to obtain more reliable data that can be used to confirm patterns of care.

Under HCQIP, there are a number of changes to the quality review process:

- the severity level-point system is eliminated;
- potential quality concerns are not pended, notification occurs immediately following identification; and
- physicians and providers are given 30 days to address letters of inquiry regarding the concern.

In addition to identifying concerns, the purpose of the quality review is to identify practice patterns associated with positive outcomes. Quarterly, WIPRO will analyze physician, provider, and statewide profiles to identify patterns of care that could be improved.

Cooperative improvement projects

Medical review, which had been the centerpiece of peer review, is meant under HCQIP to support cooperative improvement projects established by the PROs. Indeed, the final working group draft of the Clinton administration's Health Security Plan states: "the PRO program will continue to move toward analysis and improvement of patterns of health care and away from individual case review, as appropriate."[4]

An improvement project is a collaborative effort between the PRO and particular providers of care to make improvements related to a specific issue. The goals of improvement projects are:

- to improve processes and outcomes of care;
- to demonstrate and to refine a new way to produce such improvements; and
- to demonstrate that participating organizations and individuals (HCFA, WIPRO, Wisconsin physicians and hospitals) can cooperate effectively in bringing about such improvement.

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National improvement projects

Some improvement projects will be national in scope, and will be implemented by all PROs. The initial national project, the CCP, looks at the provision of hospital-based care to Medicare patients who carry a principal diagnosis of acute myocardial infarction. Wisconsin is one of four PROs that are conducting the pilot version of this project (the others are Alabama, Connecticut, and Iowa). Alabama and Iowa are looking at the issues of coronary artery bypass graft and percutaneous transluminal coronary angioplasty in addition to myocardial infarction. The CCP will be implemented nationwide after the pilot projects are complete.

The first step of the CCP has been to develop computer algorithms that are based on accepted clinical guidelines. For acute myocardial infarction, algorithms are based upon the 1990 guidelines of the American College of Cardiology and the American Heart Association. The algorithms have been reviewed by national specialty societies and by study groups in each state. On the basis of the algorithms, variables (eg, indications and contraindications) are identified on the basis of which can determine whether the guidelines were followed.

Charts on all Medicare inpatients in Wisconsin between June 1992 and February 1993 who carried a principal diagnosis of acute MI were obtained, and a team of nurses has been abstracting variables from those charts. As algorithms are created, the abstracted data is processed to determine, on a hospital-specific basis, whether the algorithms have been followed.

It is clear already that significant variations in care exist from one hospital to the next. Hospitals that follow the algorithms more closely will be considered benchmarks.

WIPRO will be visiting Wisconsin hospitals with the analysis of variation patterns. Where a hospital falls below the benchmark in a particular area, WIPRO will offer that hospital the opportunity to work in partnership with WIPRO to improve care in that area. This should result in changes in patterns of care and, ultimately, in patient outcome.

Local improvement projects

Each PRO will be developing and implementing smaller-scale local projects. In these projects, WIPRO first will identify particular clinical issues that fit the following criteria:

- the condition is frequent in the Medicare population;
- there exists a reasonably well-defined and accepted consensus;
- methods are available to measure outcomes and

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

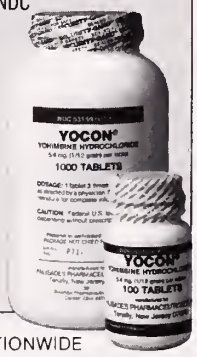
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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Continued from preceding page

risk factors;

- conforming to the consensus does not require unavailable skills or resources;
- there is a substantial, clinically important difference between the consensus and actual practice; and
- there is a substantial variation in outcomes.

Once a potential project is identified, hypotheses will be generated: both hypotheses that describe suspected patterns, and hypotheses that would explain the existence of those patterns.

Data will be obtained: data WIPRO already has, data available from other sources, or data specially collected from hospitals for the purpose of hypothesis testing. The hypotheses will be tested on the basis of data analysis.

If it appears appropriate, as with the CCP, WIPRO will work with selected providers to develop action plans to produce measurable improvement in care. And, as with the CCP, the success of a local project will be measured by whether such improvement has taken place.

Conclusion

The HCQIP constitutes a major transformation of peer review. Its intention is to improve health care systematically through application of cutting-edge thinking about quality improvement. Throughout, the element of partnership looms large. The cooperation sought is not a mere label; rather, WIPRO seeks to learn from the medical community and to support it in the task of caring for patients. The goal is for the patients' care--and, ultimately, the patients' health--to be as good as it possibly can be. This goal is shared by all physicians and health care workers, as well as by the peer review system. WIPRO looks forward to working with Wisconsin physicians toward this goal.

References

1. Jencks S, Wilensky G. The Health Care Quality Improvement Initiative: A News Approach to Quality Assurance in Medicine. *JAMA*.1992;268:900-903.
2. Institute of Medicine, Division of Health Care Services. *Medicare: A Strategy for Quality Assurance*. Washington DC: National Academy Press;1990.
3. Deming W. *Out of the Crisis*. Cambridge, Mass: MIT Center for Advanced Engineering Study;1982.
4. The White House Domestic Policy Council. *The President's Health Security Plan: The Clinton Blueprint*. New York: Times Books;1993.❖

AMA compiles "railroad Medicare" complaints

THE AMA HAS received a number of complaints over the last several months regarding the quality of claims processing service for "railroad Medicare," a federal program by which railroad retirees get Medicare benefits. The railroad Medicare carrier is The Travelers Insurance Company.

Many of the complaints focus on inappropriate payment amounts, particularly for claims submitted by participating physicians that are paid at nonparticipating physician allowed amounts. The AMA would like to gather documentation of physician experiences with this payor, including prompt and accurate claims payment, as well as payment errors and other service problems. This information will allow the AMA to assess the effectiveness of the carrier's efforts to improve its claims processing systems. The AMA will forward the information provided to the Travelers.

Fax your comments about "railroad Medicare" to Rose B. Heald, AMA Department of Health Care Financing, 312-464-5849, or e-mail on the AMA Electronic Network. You can mail your comments to: American Medical Association, Department of Health Care Financing, 515 North State, Chicago, IL 60610, Attention: Rose B. Heald.❖

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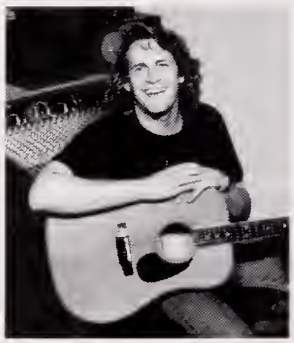

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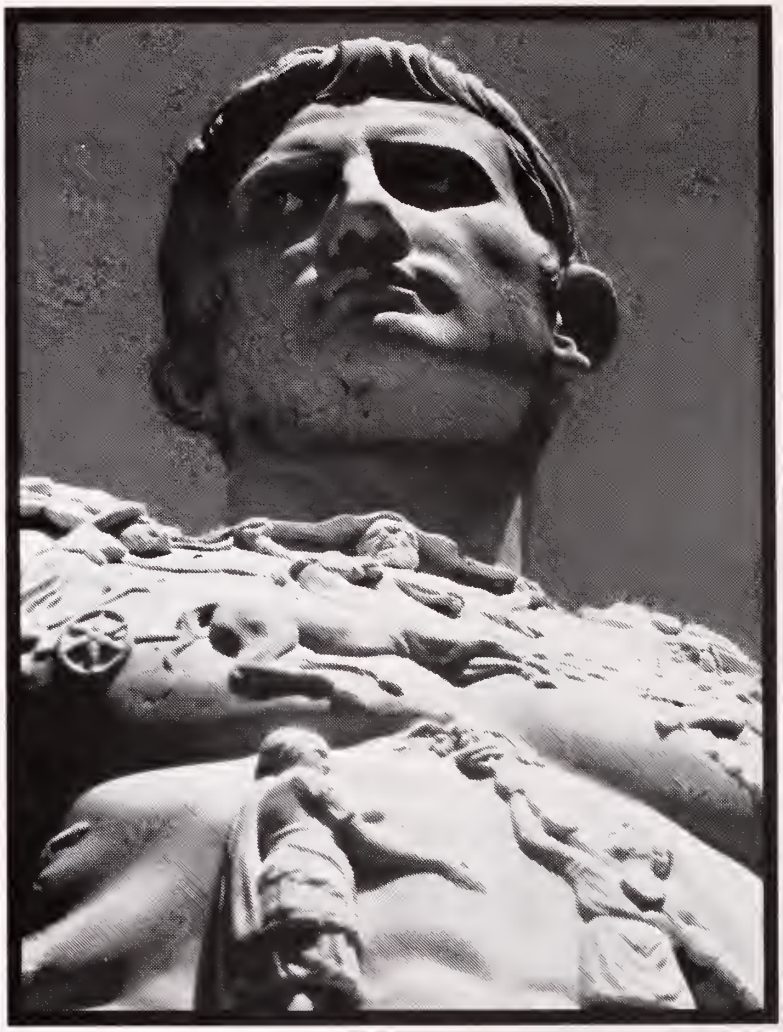

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Mike²: A potent formula for organized medicine

Shari Hamilton, assistant editor

AT FIRST THEY SEEM an odd combination. Mike and Mike. A San Francisco sophisticate and a farm boy raised in rural Washington state. Yet, this unlikely pair has proved to be a winning combination for organized medicine. Joining forces, Mike Bigelow and Mike Armstrong have resuscitated the medical student chapter at the Medical College of Wisconsin with an enthusiasm that has rippled through the MCW student body and brought them national recognition through their selection as recipients of the 1994 AMA/Glaxo award.

"Most people know us as `Mike and Mike,'" Michael Armstrong explained in a recent *WMJ* interview. "Since we do this together, we've become interchangeable in their minds." Both Mikes have found that mistaken perception sometimes works to their advantage; each student has been publicly credited with both his own accomplishments and that of the other Mike.

"It's great," they proclaim in unison, grinning broadly.

Both medical students will stay in Wisconsin at least for a while. Bigelow will pursue a dual doctorate and medical degree program while Armstrong will begin a residency in emergency medicine.

How did the unlikely alliance of Mike and Mike form? Coincidence more than anything played a leading role.

Medical students Mike Bigelow (l) and Mike Armstrong (r) stop by the WISPAC booth at the SMS annual meeting to learn more about how organized medicine helps shape public policy and legislation. The Medical College of Wisconsin students are credited with having revitalized the medical student chapter at their school. (Photo by Carole Pollack.)

"We met on the first day of class, during orientation week," Armstrong remembers. "(Mike Bigelow) sat down next to me. As our friendship grew and we found out that our interests were very similar and our ideas were enough similar that culminated in us deciding to run as co-presidents."

Bigelow had some strong second-hand knowledge of medical politics. His father, a family physician in the San Francisco Bay area, had served as a state delegate. His mother is a past president of the California medical auxiliary.

But Armstrong admits, "I joined the AMA as a freshman the first day of school. I didn't even know what the AMA was all about."

When the medical student duo discovered the medical student

Continued on next page

Continued from preceding page
organization had become nearly dormant, the "Mikes" launched a campaign for revitalization.

"As soon as we were elected," Armstrong explains, "everything was pretty much dropped in our laps. We came into an organization that had very little structure, but a little bit of a budget so we felt like we could do something. I had never done anything really political in the past. I was president of my senior class so I had a little bit of leadership experience."

"Basically, both of us are outgoing enough and we're not intimidated by anything," says Armstrong, describing their course. "We called Bill Harlan (then-executive vice president for the Medical Society of Milwaukee County) at the county; he helped us immensely. Various people at the state society helped us."

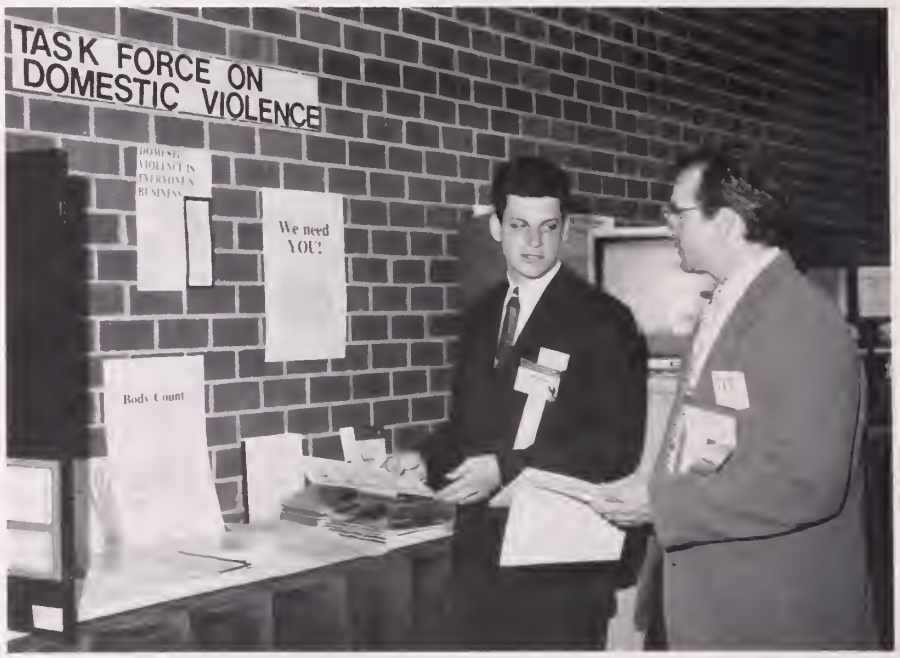
Undaunted by inexperience, the medical students jumped right in, implementing a "trial and error" approach. Explains Armstrong: "I wrote a resolution my sophomore year and spent a lot of time on it. That was the first resolution ever written by someone in our chapter."

The would-be proud moment, however, was swept away when someone from the AMA Governing Council stood up as the resolution was introduced and pointed out that such a statement was already published in the AMA's policy compendium.

"Bam! End of topic," Armstrong grimaces, recalling the crushing blow.

The research lesson well learned, the students returned to Milwaukee and went back to work. They continued to recruit MCW students, earning an AMA achievement award for recruiting 75% of the incoming class.

"I'm a salesman, I admit it," Armstrong chirps. "If I hadn't gone to medical school, I would have been a great salesman. I made a lot of promises and I sold the organization. In retrospect, I think we came through. None of the committee work or resolutions had been done before. But we did it. We came through.



Public health issues such as domestic violence top the list of concerns medical students Mike Armstrong and Mike Bigelow have for the wellbeing of their future patients. Bigelow helped organize a three-segment session on domestic violence at the Medical College featuring talks by past SMS President William J. Listwan, MD, and Kevin Fullin, MD, both leaders in the movement to end domestic violence in our state. (Photo by Carole Pollack.)

"We came back to the next meeting and I wrote a smoking in prisons resolution that actually is now policy of the AMA," Armstrong says. "It was passed by the AMA House of Delegates and it was the first resolution ever written by our school that got that far."

The last AMA meeting proved a banner experience for the Milwaukee student chapter, recalls Bigelow, who served as chair of the credentials committee while Armstrong served on a reference committee. "We put in four resolutions and three of them passed. Two went to the House of Delegates ... and one got referred to the governing council, which now looks like it's going to full-length hearing for long range planning," he said.

"Writing resolutions got us involved in the meeting and got us involved in every step of the process. Not only us, but our whole delegation was involved in politicking behind the scenes at the national meeting," Armstrong said.

Although they were welcomed warmly by county and state medical societies, Bigelow said they originally found the national level of organized medicine hard to crack. "The first three meetings they thought we were from Madison," Armstrong recalls ruefully. "If you don't know anyone or your school has never done anything, you don't get any where very fast. But we broke those barriers down in the last year and a half to a point where Mike and I are well recognized at national meetings."

Notes Bigelow, who has served as medical student representative to the SMS for 2 years: "The (federation) has been extremely accommo-

Continued on page 228

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Continued from page 226
dating to students because they are interested in getting students involved at the county, state and national levels."

About 500 medical students now belong to the MCW chapter and Bigelow says that representation makes it more and more likely that student views will be considered in organized medicine's decisions. "There have been occasions at state society meetings where someone has stood up and asked for the medical students' opinion of an issue such as workplace planning or something that was being talked about."

"Our AMA delegates from Wisconsin have gone out of their way," Bigelow says, "to take us under their wings at national meetings, take us to their caucuses and their receptions and introduce us to the movers and shakers at the national level."

"When we see (SMS delegates and staff), they are up-to-date with the resolutions we've written over the years and give us feedback on what we've done," Armstrong says. "It hasn't always been in agreement, but generally it's been close. I don't think we could have done a lot without the support of our state society. I think we've been pretty fortunate."

The recognition culminated in February when Armstrong and Bigelow were selected to receive 1994 AMA/Glaxo awards during a special ceremony in San Francisco. The award is presented to medical students and resident physicians who have exhibited outstanding leadership abilities in organized medicine, civic or non-clinical medical school or hospital activities. The many achievements to their credit include: work as medical coordinator of a free clinic for the uninsured; organization of a letter writing campaign on behalf of the Higher Education Act; development of a domestic violence seminar at MCW; and service on numerous committees, often as committee chair.

Mike Bigelow (l) receives the AMA/Glaxo Achievement Award from Lonnie Bristow, MD, (r) chair of the AMA Board of Trustees.

Having matched in Wisconsin, Armstrong plans to work on developing the state's resident section next. "I think residents generally think they are too busy; that there's not enough time in the day. But I think that physicians have historically shot themselves in the foot too many times by not being active."

"The big selling point," Armstrong said, "that I've always made when I recruit students is: "Decisions are being made every day of your life about your career on Capitol Hill in Madison and Capitol Hill in Washington, DC. Those decisions are being made and you were a part

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

Black, David Phillip
* Budzak, Kathryn Sue
Cullinan, John Paul
* Elias, Sharon Louise
Kampschroer, Bernard Hugh
* Lamps, Gary Martin
* Myers, Franklin Lewis
* Oujiri, John Charles
Robnik, Spencer Louis
* Todd, Paul Clark
* Turnbull, James Michael
Vitale, Blaise Paul❖

of the career of medicine the day you walked through this door. And as a medical student, now is the time for you to get involved in those decisions as they're being made.

"Medicine is very political," Armstrong observed. "It's the nature of the beast: You cannot avoid it, whether it's hospital politics or between departments or whatever."

Bigelow agrees. "I think it will be a lot easier for our generation to get our peers involved. We are the first real generation that has grown up with the new health care values--the managed care and the increased politics that are now a part of health care and payment teams and what not and all the acronyms that have come out in the federal and state levels. Mike and I might have been a little ahead of the curve in terms of really getting involved early and being politically aware of our role in shaping our future careers, how those careers would be affected by politics. I think our generation is more aware and it will be easier in the future to get students, residents, young physicians and physicians involved.

"At the SMS and the national level there's a new emphasis in bringing young people into the organization. The AMA just recently explicitly put in a seat on their board of trustees for a young physician. There had been one for a resident physician and 2 years ago, they finally gave the student member full rights, but there hadn't been a separate designation for a young physician so there was a huge age gap on the board of trustees.

"Our professional generation is realizing the importance of participation," Bigelow said, "and it will be easier in the future to get medical students involved."❖

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Session II — Peter Brill, M.D., Alan McLean, M.D. & Len Sperry, M.D., Ph.D. — Effective Organizational Consultation: Developing the Necessary Skills
Session III — James Gustafson, M.D. — The Essentials of Brief Psychotherapy for Families, Couples and Individuals

August 1-5
Session IV — Glen O. Gabbard, M.D. — Psychotherapeutic Strategies with Borderline Patients
Session V — Diane Adile Kirschner, Ph.D., & Sam Kirschner, Ph.D. — Treating Survivors of Incest and Abuse
Session VI — Mariellen Fischer, Ph.D., Thomas A. Hammeke, Ph.D., Robert F. Newby, Ph.D., Steve M. Rao, Ph.D., & Sara J. Swanson, Ph.D. — Advanced Topics in Neuropsychological Assessment and Treatment

August 8-12
Session VII — John H. Greist, M.D., James W. Jefferson, M.D. & David J. Katzelnick, M.D. — Psychopharmacology Consultations
Session VIII — Jeffrey A. Kelly, Ph.D., David G. Ostrow, M.D., Ph.D., & Kathleen J. Sikkema, Ph.D. — AIDS/HIV Prevention, Therapy, and Mental Health Consultation Issues

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Physician briefs

The * indicates a member of the SMS.

Jordon Fink, MD, professor of medicine and chief of the division of allergy and immunology at the Medical College of Wisconsin, has recevied the American Academy of Allergy and Immunology's Distinguished Service Award. Dr Fink received the award in recognition for his efforts and achievements in signifcantly enhancing the scientific and educational goals of the academy through the development of new fund sources.

Farhat N. Khan, MD, a pediatric gastroenterologist, has joined Gastroenterlogy Consultants, Ltd., in Racine and Milwaukee. Dr Khan recently completed her pediatric residency at the University of Kansas Medical Center and her pediatric gastroenterology fellowship at Children's Hospital Medical Center in Cincinatti. She is board certified in pediatrics.

Jim Milford, MD,* will head up the new Lakewood Family Clinic in Lake Mills. Dr Milford will specialize in family practice, including obstetrics. Dr Milford graqduated from Loyola University Medical School in Chicago and completed his residency at St. Michael Hospital in Milwaukee.

Patrick O'Brien, MD,* has become a consultant for Ripon Medical Center. Dr O'Brien is in practice in Neenah as a cardiology specialist. A graduate of the University of Wisconsin Medical School, Dr O'Brien served an internal medicine internship and residency and completed a 3-year fellowship in cardiology at the Medical College of Wisconsin in Milwaukee. He is board certified.

Richard P. Reigel, MD,* is relocating his practice. Dr Reigel is a urological surgeon at St Michael's Hosptial in Stevens Point. He plans to continue with the Stevens Point Hospital and move his practice from Stevens Point to Waupaca.

Daniel Rudman, MD, professor of medicine at the Medical College of Wisconsin, and a nationally recognized specialist in geriatric wellness and nuitrition, has been named a fellow of the American Instiute of Nutrition. Dr Rudman is associate chief of staff for extended care at the VA Medical Center, where he conducts much of his research into aging.

Sheryl Spadone, MD, has been appointed medical director of the Cornell Area Care Center. Dr Spadone, a family physician, is a 1990 graduate of the Ohio State University College of Medicine and is a diplomate of the National Board of Medical Examiners.

James Tweddell, MD, has been appointed assistant professor of cardiothoracic surgery and director of the cardiac transplantation team at the Medical College of Wisconsin.

Kirby appointed to AMA advisory group

The AMA recently appointed Mike Kirby, director of SMS Government Relations, to its state advisory group. The 11-member advisory panel provides the AMA with state-level insight on the AMA's regulatory and legislative efforts, and is expected to play a key role in assisting the AMA's government and political affairs staff in developing organized medicine's response to the ever-changing health system reform debate.

"By appointing an SMS representative to this vital advisory group, the AMA recognizes the significant influence members of the Wisconsin Congressional delegation may have on health system reform. Mike Kirby is an excellent spokesman for Wisconsin physicians and patients so I believe our views will be thoroughly considered," said Thomas L. Adams, CAE, SMS executive vice president. The advisory group also works to communicate to the AMA concerns that state societies have with other federal issues such as Medicaid and ERISA. ❖

Michael Kirby

Dr Tweddell comes to the Medical College from St. Louis where he had spent the past 7 years completing research and clinical residencies in cardiothoraciuc surgery and a residency in general surgery at Washington University Medical Center.

Barry H. Usow, MD,* of Mequon, has been elected president of the medical staff of St. Luke's Medical Center for a term of office ending in 1995. Dr Usow has been practicing urology in Milwaukee for 20 years. He is a past president of the Milwaukee Urologic Society as well as past president of the University of Wisconsin Medical School Alumni Association. He is currently president elect of the Wisconsin Urologic Society.

Jerome Veranth, MD,* a board certified otolaryngolist, has joined the Rhinelander Medical Center. Dr Veranth was in private practice in Racine since 1968. He earned his medical degree at Marquette University in 1961 and served a rotating internship at St Marys Hospital in Duluth. He completed his residency in otolaryngology at the Marquette University School of Medicine Affliated Hospitals. Dr Veranth is a fellow of the American College of Surgeons and member of the AMA, American Academy of Ophthalmology and Otolaryngology and the Alpha Kappa National Medical Fraternity.❖

SMS enters agreement with electronic claims network

THE SMS HAS entered an agreement with United Proservices, Inc., the largest electronic insurance claims network in the state, to provide members with the opportunity of transferring insurance claims work to a computer network and reduce paperwork.

"We are continuing to encourage our members to participate in the electronic evolution of business practices because this will help physicians to reduce the paperwork costs that drive up health care costs," explained SMS Executive Vice President Thomas L. Adams, CAE.

The network will handle insurance claims from numerous companies. After the bills are transmitted electronically from the physicians' offices to a central clearinghouse in Pewaukee, Proservices will sort out the bills and send them on to their proper destinations.

The Proservices network is a model of the information superhighway the White House is pushing to help lower the nation's health care bill. It uses computers and telephone lines to instantly transmit billing information and other insurance data between medical offices and insurers.

SMS members will need a computer with a modem to access the network. Proservices will supply the necessary software. Based in Milwaukee, Proservices is part of the publicly held arm of Blue Cross & Blue Shield United of Wisconsin, Inc. The firm is among the most technologically advanced insurance processors in the nation. For information, contact Proservices Marketing Director Dave Fularczyk at (414) 226-5123.❖

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County society news

Dane. The following members have been accepted by the Dane County Medical Society: Peter Canaday, MD; Lee Faucher, MD; Brian Hirsch, MD; Linda Jankelow, MD; Masoud Khorsand-Sahbaie, MD; Maritsa Koburov, MD; Sharilyn Munneke, MD; Christopher Pelzek,MD; Chrys Synstegard, MD; and Brad Wozney, MD.

Fond du Lac. Conrad L. Brimhall, MD, and Amy M. Rosenblatt, MD, have been accepted in the Fond du Lac County Medical Society.

Marathon. The Marathon County Medical Society approved membership for Randal C. Kumm, MD.

Milwaukee. The following physicians have been accepted into the Medical Society of Milwaukee County: David K. Ashpole, MD; Stuart E. Blacher, MD; Melbourne D. Boynton, MD; James C.Byrd, MD; John Eversman, MD; David H. Fingard, MD; Lanny Brian Hale, MD; James F. Helm, MD; Safwan S. Jaradeh, MD; Mark Stephen Kermgard, MD; Robert Mark Kliegman, MD; Peter Mark Layde, MD; John Francis Lesko, MD; Enid A. Okokon, MD; William Glenn Raasch, MD; Joesph M. Romano, MD; Thomas John Ryan, MD; Jeffrey S. Simon, MD; David D. Smyers, MD; Simon Tan, MD; James Peter Thomas, MD; Ahdi Amer Amer, MD; Marian E. Asfeld, MD; Aasma Aziz, MD; Ray S. Bender, MD; Cindy Carol Bitter, MD; Maelynn D. Colinco, MD; Jan Alexis Doenier, MD; Lawrence D. Drewsen, MD; Cathy Rae Fakler, MD; David A. Ferber, MD; Catherine A. Fleming, MD; Shari R. Gabriel, MD; Jaime Gonzalez Ruvalcaba, MD; Thomas P. Gutmann, MD; Anthony P. Haas, MD; John A. Haggstrom, MD; Daniel P. Holub, MD; William G. Hope,

Continued on next page

Request for bids issued in Waukesha County

THE STATE Medicaid program has released a "request for bids" to health maintenance organizations interested in providing HMO services to certain Medicaid recipients in Waukesha County.

The program, similar to the HMO system in effect for Medicaid recipients in Milwaukee County, will target managed care services to Aid to Families with Dependent Children (AFDC) and Healthy Start recipients. The deadline for submitting bids is June 16.

The HMO contracts are intended to run from Aug 1, 1994, to Dec 31, 1995. Medicaid officials held informational meetings recently with health care providers in Waukesha County about the plan.

According to the 1993-1994 Blue Book, about 1.3% of Waukesha County residents are AFDC recipients eligible for the MA HMO.❖

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MD; Victor Kan Hu, MD; George C. Huang, MD; Smriti S. Khare, MD; Cliona M. Kilmartin, MD; Jeffrey A. Marsh,MD; Marcella T. McCord, MD; Nadia Moussavi, MD; Adan E. Nigaglioni, MD; John M. Obert-Hong, MD; Theresa Ann Oswald, MD; Thomas J. Parks, MD; Amy L. Pappin, MD; Mohan V. Pillai, MD; Ma Estelita F.G. Quejada, MD; Mohammad S. Razzaq, MD; David W. Schulz, MD; Prateek Sharma, MD; Tammy L. Sims, MD; Katrina Spears, DO; John D. Suson, MD; Joel Cameron Swanson, MD; and Mislav Tonkovic-Capin, MD.

Oneida-Vilas. The Oneida-Vilas County Medical Society approved membership for Jerome J. Veranth, MD.

Ozaukee. Gwenn Pavlovitz, MD; and Christopher Felton, MD, have been accepted into the Ozaukee County Medical Society.

Pierce-St. Croix. The following physicians were approved for membership in the Pierce-St. Croix Medical Society: Kari M. Campbell, MD; Taylor E. Neff, MD; Nickolas P. Tierney, MD; Robert J. Stoy,MD; Paul W. McGinnis, MD; Patrick J. McCann,MD; Kathleen C. Antolak, MD; Steven F. Adorn, MD; and Kevin D. Helmen, MD.

Racine. Christene A. Timmons, MD, has been approved for membership in the Racine County Medical Society.

SMS Executive Vice President Thomas L. Adams, CAE, (l) confers with Richard Turman, (c) a legislative aide to Sen Herb Kohl, and SMS Board Member Paul Wertsch, MD, (r) during a recent visit to Washington, DC, by representatives of organized medicine from around the country.

Rock. The Rock County Medical Society approved membership for the following physicians: Karen E. Bhaskar, MD; Richard A. Clutson, MD; Terence S. Edgar, MD; Rex J. Kolste, MD; Alfredo F. Mendoza, MD; and William M. Wilson, MD.

Sheboygan. The following physicians have been accepted in the Sheboygan County Medical Society: Louie Coulis, MD; Frank E. Cummins, MD; Stephen T. Denker, MD; Martin Reichman, DO; and Lee S. Wann, MD.

Waukesha. Robert M. Dhein, MD; Greg T. Heal, MD; Timothy J. Hill, MD; and Mark A. Klaas, MD, have been approved for membership in the Waukesha County Medical Society.❖

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Obituaries

Balder, Roy B., Jr., MD, died April 16, 1994, in Hillsboro. He was born June 30, 1926, in Chicago. He received his medical degree from the University of Colorado Medical School and interned at the Detroit Memorial Hospital. He lived in Elroy since 1962, where he was a private practice physician for 30 years before his affiliation with the Gunderson Clinic. Dr Balder was on the medical staff of the St. Joseph's Memorial Hospital for more than 30 years. He is survived by his wife, Lee of Elroy; a son, Roy B. III "Chip" of Vernon Hills, Ill; three daughters, Carolie Kuehn of Wausau, Mary Beth Balder-Schroeder of Holman, and Jeanne Brock of Onalaska; two grandchildren; a brother and a sister.

Hacker, Louis C., MD, died March 20, 1994, in Marshfield. Dr Hacker was born Aug 13, 1942, in Albany, NY. He received his medical degree from Albany Medical College in 1969, and served his internship and residency in Illinois and Ohio. He held academic appointments as assistant and clinical instructor at colleges in Ohio and New York and as clinical instructor in plastic surgery at the University of Wisconsin College of Medicine. He served in the US Army National Guard and Reserve Medical Corps from 1970 to 1977, completing his service with the rank of captain. From 1976 to 1984, he specialized in plastic surgery in Troy. He had been practicing plastic surgery with the Marshfield Clinic since August 1984, having been elected chair of the plastic surgery section in 1987. He was active in the Marshfield Geneology Group. He was the immediate past secretary treasurer and past president of the Wood County Medical Society and a delegate to the SMS House of Delegates. He was a diplomat of the National Board of Medical Examiners and the American Board of Plastic Surgery. He was a member of the AMA and the American Society of Plastic and Reconstructive Surgeons. Dr Hacker is survived by his wife, Helen;three daughters, Susan Webb Hacker of Chandler, Ariz, Sandra Webb Hacker and Janet Webb Hacker of Marshfield; his mother; two brothers, and two sisters.

Halser, Joseph G., MD, died March 9, 1994. He was born Nov 1, 1905. He received his medical degree from Marquette University Medical School and served an internship in family practice at Mt. Sinai Hospital in Milwaukee. He served a residency at the Ev. Deaconess Hospital in Milwaukee. Dr Halser was a member of the Medical Society of Milwaukee County, and an SMS 50-Year Club member. He served as medical director of the Ladish Company in Cudahy. Dr Halser is survived by his wife, Dorthea; three sons, Joseph III, Robert and William; and six grandchildren.

Jachowicz, Robert B., MD, died April 8, 1994. He was born Jan 26, 1937, and received his medical de-

Continued on next page

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gree from Marquette University. He served his internship at St. Luke's Hospital in Milwaukee. He served in the U.S. Navy Reserve as a medical officer on active duty during the Vietnam war. Dr Jachowicz was a general practitioner in Hales Corners. He was chief of the Department of Family Practice at St. Francis Hospital in Milwaukee from 1971 to 1974. He was a member of the AMA, SMS, and the American Academy of Family Practice. He is survived by his wife, Bonnie; his children, Jill Barrierre, Joy Margaret Gilbert, Judith Arnsdorff, Robert II, and Jane; a brother; and six grandchildren.

Jansen, Ruth L., MD, died March 29, 1994, in Milwaukee. She received her medical degree from the University of Chicago and completed her residency and internship in Milwaukee. She was chief of psychiatry at St. Luke's Medical Center until she retired in the mid-1980s. Dr Jansen is survived by her husband, Allen R. Jansen; three daughters, Patricia LeStarge of Overland Park, Kan, Mary VanPatten of Scotia, NY, and Susan Strenk of Wauwatosa; two sisters and a brother.

Reyes, Cesar N., Jr., MD, died March 28, 1994, in Marshfield. Dr Reyes was born Sept 14, 1931, in Manila, Phillippines. He received his medical degree in 1951 from the University of Santo Tomas. He interned at St. Francis Hospital in La Crosse, and served his residency in pathology at Swedish Hospital, Minn. He worked as a pathologist at St. Bonifact Hospital in Winnipeg, Manitoba, Canada from 1962 through 1966. He joined the staff of the Marshfield Clinic in 1966, and had been a member of its board of directors since 1969. He was chair of the Department of Pathology from 1968 through 1972, director of the joint venture laboratory from 1975 through 1986, vice president of the clinic 1980-1981, and 1983-1985, and a member of its executive committee from 1973 through 1975, and 1977 through 1987. He was an American Group Practice delegate from 1976 until his death, a member of the American Group Practice Association Board of Trustees from 1985 through 1988, director of the school of cytotechnology from 1971 through 1993, director of the school of histotechnology from 1967 through 1993, and director of the school of medical technology from 1967 through 1992. He is survived by his wife, Karen; two daughters, Laura and Teresa; his mother and four sisters.

Saladar, Rafael S., MD, died April 2, 1994, in Rockford, Ill. He was born Sept 18, 1933, in Bacolod City, Philippines. He graduated from medical school at Manila Central University in Manila, Philippines. He had a medical internship at Augustant Hospital and a residency in family practice at Weiss Memorial Hospital, Chicago, Ill. He spent 4 years of residency in general surgery at Illinois Central Hospital in Chicago, after which he worked part-time as an industrial physician at Gary Steel Mills, Gary, Ind. Prior to his death, he had been in family practice and general surgery in Beloit and Sharon, WI. Dr Saladar was a member of the Rock County Medical Society, the SMS, American Society of Abdominal Surgeons, and the Philippine Surgeons in America. He is survived by his wife, Norma; a daughter, Elma Joyce Saladar (Dr. Greg Olson), Rapid City, SD; two sons, Rafael Saladar, Jr., and Daryl Saladar, Beloit; three brothers and five sisters.

Sattler, Chester A., MD, died April 15, 1994, in Kenosha. He was born Dec 3, 1912, and received his medical degree from Rush Medical School in Chicago. He was an orthopedic surgeon. Dr Sattler was founder and a life member of the research department of the American Academy of Orthopedic Surgery, and was a member of the Wisconsin Orthopedic Society. He was also a member of the Medical Society of Milwaukee County, SMS 50-Year Club, and the AMA. Dr Sattler is survived by his wife, Mary; two sons, Richard B. of The Woodlands, Texas, and Rex B., Kenosha; two brothers; a sister; and two grandchildren.

Temple, Robert L., MD, died April 10, 1994. He was born Nov 13, 1926, and received his medical degree from the University of Wisconsin Medical School. He served an internship at Madison General Hospital, and his residency in anesthesiology at the Veterans Administration Center in Wood. Dr Temple is survived by his wife, Lucille; and his children, Neal Gross, James Temple, Elana Hoerig, Robert Scott Temple; two brothers, a sister, and seven grandchildren. Dr Temple was preceded in death by his daughter Virginia Stauffacher.

Wisler, Robert J., MD, died Feb 25, 1994. He was born April 28, 1957, and graduated from the Medical College of Wisconsin. He served his residency and internship at the Medical College of Wisconsin and Mt. Sinai Medical Center. Dr Wisler specialized in anesthesiology. He is survived by his lifetime partner, Clark Williams, and his parents.❖

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Methods--Describe the selection of observational or experimental subjects, including controls. Identify the methods, procedures and equipment well enough to allow replication.

Results--Provide results in the test, tables or illustrations. If tables or illustrations are used, emphasize or summarize only the most important observations in the text.

Discussion--Discuss the conclusions that follow from the results, as well as their limitations and relations to other studies. Show how the conclusions relate to the purpose of the study. Recommendations, when appropriate, may be included.

References--Limit to 20. Authors are responsible for the accuracy and completeness of references. References must follow AMA style and abbreviations of journal names must follow those in *Index Medicus*. Consult the *Wisconsin Medical Journal* for examples of proper form.

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- Units of measure are to be provided in metric, followed by International System units (SI) in parentheses.
- Provide each author's full name and highest academic degree in the

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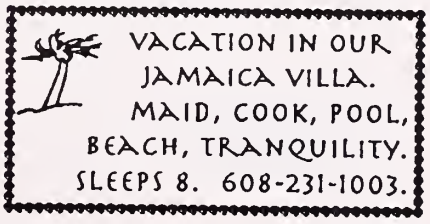
AMA

June 12-16, 1994: Annual AMA House of Delegates, Chicago.
December 4-7, 1994: Interim House of Delegates, Honolulu.

Miscellaneous



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Palisades Pharmaceuticals, Inc. 221
Peppino's Restaurant 199
Physicians Insurance Company of Wisconsin ..... BC
SMS Insurance Services, Inc. 197, 227
TransGlobal Tours, Inc. 229
T. Rowe Price ..... IFC
Schering-Plough 209-210

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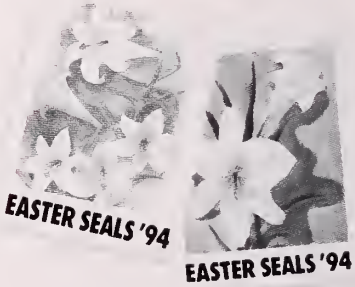

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Wisconsin Medical Journal

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Contents

June 1994 Vol. 93 No. 6

Opinions

245 *President's page*
Answering the call
by Richard G. Roberts, MD, Madison

246 *EVP report: The view from here*
Addressing some issues raised by our recent survey
by Thomas L. Adams, CAE, Madison

251 *Soundings*
Farewell to a friend: Morry Schroeder, MD, 1908-1994
by Wayne J. Boulanger, MD, Milwaukee

253 *Letters*
Lyme disease and Hippocrates
by Steven D. Reske, Esq., Minneapolis

Scientific

257 Lead in breast milk: Should mothers be routinely screened?
by Laurie Tellier, MS, RN, and Richard A. Aronson, MD, MPH, Madison

261 Takayasu's arteritis: a report of three cases
by Sharmishtha Raikar, MD, and Shereif Rezkalla, MD, Marshfield

266 Survival 13 years after pancreatectomy for ductal adenocarcinoma of the head of the pancreas
by Eugene E. Eckstam, MD, Monroe

Socioeconomic

271 Clarifying goals, improving communication, and finding joy in the doctor-patient relationship
by Randy Maigaard, MD, and David Schiedermayer, MD, Milwaukee

275 *Public health*
Self-reporting of Papanicolaou smear tests among women after hysterectomy
by Katherine M. Kvale, PhD, Patrick L. Remington, MD, MPH, and Paula M. Lantz, PhD, Madison

277 AMA unveils legislative initiative to protect patients

Organizational

279 A glimpse into our past
by Richard D. Sautter, MD, medical editor

281 New members appointed to restructured SMS commission

282 Physician briefs

283 County society news

284 *Wisconsin Medical Journal* instructions to authors

Our cover: Michelangelo's "Madonna and Child" drawing in crayon and chalk. Our cover story begins on page 257.

Wisconsin Medical Journal

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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President's page

Answering the call

Are politicians leaders? Are physicians? Certainly, we recognize leaders have sprung from both professions, but what is the quality--if, indeed, there is just one--that separates the leaders from the led?

Leadership exhibits itself in several styles. The president of the United States--regardless of his politics--is viewed as a "status leader," someone permitted to direct by virtue of his or her position or office held. Martin Luther King, Jr., is a strong example of a "charismatic leader," one who prevails through force of personality or ideals, while Mother Teresa has walked the path of a "servant leader," someone who derives his or her influence from meeting followers' needs. "Transformational leaders" draw out leadership and other abilities from followers ("Give people fish and they eat for a day; teach them to fish and they eat for a lifetime."). An ideal leader uses the style best suited to his or her skills and the demands of a situation.

Each of us is a leader at times and a follower at times. Most often, we content ourselves with the relative anonymity and safety of followership. The energy and commitment required to lead can give way (and sometimes should) to the pressures and pleasures of family and practice. We may shy from the leadership spotlight or feel ourselves not up to the challenge. *What, me lead? I can't even lead in silent prayer.*

Richard G. Roberts, MD, JD

Physicians **do** lead, overtly and covertly. We hold status leadership positions on school boards and in the Legislature. We provide charismatic leadership as we speak out with conviction on issues of concern. We exemplify servant leadership as we reach out to the dispossessed through homeless clinics and missionary hospitals. We strive for transformational leadership when we enable patients or communities to take control of their health fu-

Continued on next page

Special issue on violence

SMS President Richard Roberts, MD, JD, hopes to help physicians fight the rise of death and injury from gun violence in Wisconsin during his term. In coordination with the campaign, the *Wisconsin Medical Journal* is seeking articles from Wisconsin physicians on the subject of gun violence, exploring its nature, causes, costs, effects, and possible solutions. The special issue is tentatively set for September, and papers for it must be submitted no later than Aug 1.

There is room in the *WMJ* for approaching the issue from many angles: scientific, socioeconomic, and organizational articles, as well as letters of opinions and expression of personal experiences and feelings in "Soundings."

Guidelines for writers are available from the *WMJ*: 257-6781 (Madison area) or 800-362-9080.❖

Continued from preceding page
tures.

Conversely, our silence also provides leadership whether we wish to acknowledge it. When we choose not to speak out on the issues of our times, we risk being wrongly perceived as apathetic, uncaring or silent advocates of a future we would rather not see (eg, another generation of Americans addicted to nicotine).

The health problems we face today can seem impossibly complex, rooted as so many of them are in personal habits and lifestyle, poverty, racism, social disruption, and unemployment. It can be tempting to turn inward and focus solely on the individual patient before us and ignore the community that surrounds us.

Yet our very essence as professionals depends on our willingness to speak out to a larger community: in Hippocrates' time being a professional meant that you "professed"--that you declared publicly that you were a healer and helper of the sick. Our ability to lead as physicians arises out of our credibility and visibility in the community, our technical expertise, our professional commitment to put service to others above self, and our willingness to speak out, to profess our concerns.

The need for physician leadership is unprecedented. As we minister daily to the suffering, we take in a wide array of failings and foibles that we call humankind. We have a duty to profess the problems that we encounter and the solutions we envision. Our patients and the public look to us for guidance on issues of the day as exemplified by recent polls showing that two out of three Americans believe that physicians are the best architects of a reformed health system.

We are, like most leaders, dealers in hope. We are opinion shapers and influence leaders. We must not limit our domain to the examination room or hospital ward; our responsibility stretches from our patients to our community. We must answer the call to community to fulfill our calling. ❖

EVP report: The view from here
Addressing some issues raised by our recent survey

Our recent all-member survey is producing a wealth of useful information that will be invaluable when the SMS leadership begins the next phase of updating the SMS strategic plan.

A future *WMJ* will provide a full report on the survey data, which is still being compiled, but the open-ended comments section produced some remarks and questions that were either illustrative or in need of reply. I'd like to address some of them here.

- (I'd prefer) a less doctrinaire politically conservative stance.
- Do not be so liberal in the political sense, many of your members are not socialists, but somewhat conservative.
- Stop being so ultra conservative....
- Quit listening to the liberals in government.
- Society is governed by conservatives and does not address either my political views or my needs.

I found this amusing, enlightening and gratifying. Our liberal physicians think the SMS too conservative; our conservative physicians think it too liberal. Further evidence to back Dr JD Kabler's adage that "How you stand depends on where you sit."

At first blush, this may appear as a bad omen indicating that the SMS, in pleasing neither end of the political spectrum, is pleasing no one. I think this is the wrong interpretation. Instead, I think this says that the SMS--being to the right of the left and to the left of the right--is achieving the political moderation that best suits a broad-based, nonpartisan organization. I think it tells me that our positions on candidates and legislation have been based on what is best for medicine and your patients, and not on political ideology. And that is as it should be.

Thomas L. Adams, CAE

These responses also tell me that there is room for everyone in the

Continued on page 248

...a promise to defend...

HERE ARE THE FACTS: Over 25% of America's Physicians were embroiled in a malpractice issue in the last 12 months. More than 80% of those malpractice allegations will be closed without an award for damages. Your professional reputation and your personal assets are on the line when your professional liability carrier is not both financially sound *and* experienced in the law and the judicial system.

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Continued from page 246
SMS, that it is a genuinely democratic organization, and that makes me even prouder to be part of it.

- The SMS is tailored for solo MDs, not for group physicians like me.
- It seems the SMS now represents corporate medicine to a greater degree than individual solo physician....

This is very similar to the comments about the SMS being too liberal or two conservative. If the group physicians think the SMS favors the solo practitioner, and the solo doctors think it favors the groups, then the organization must be doing significant work on behalf of both types of physician. Again, this is as it should be; again, there is room enough for all in the SMS.

- I feel medical society only represents, and is controlled by, highly paid super-specialists---doing nothing about representing low-paid, hard-working primary care.
- There is not enough being done to promote primary care MDs.
- Stop presenting primary care prejudices as the opinion of all physicians.
- Pay more attention to specialists....

Here is a third example of how well the SMS is doing at serving its diverse membership. Some primary care physicians think the organization is geared toward specialists, and some specialists think the SMS does too much for primary care doctors--similar to the group v solo comments and the liberal v conservative remarks.

The disturbing part of such comments is that they indicate there are those among us who see medicine's issues in black-and-white terms of "us against them." From my experience, however, I am confident that the vast majority of SMS members perceive the gray shades of most issues and can clearly see the common ground where physicians of all sorts can--and do--meet and work together. It may be useful to remind ourselves that our political opponents would enjoy nothing more than seeing the house of medicine divided against itself. United, physicians are formidable; divided, they are easy prey.

- Break ties with AMA!

As a matter of fact, the SMS is not a unified society with the AMA. Wisconsin physicians can join the SMS without joining the AMA.

The SMS does send a delegation to the AMA and does have physicians represent it and you in the AMA House of Delegates and in leadership positions on AMA commissions (and this month, Dr Tim Flaherty is running for the AMA Board of Trustees). Right or wrong, when the AMA speaks the nation hears it as the voice of medicine, so it is important that Wisconsin have some part in determining what that voice is saying.

- I have come to the SMS twice with problems. You were of no help the first time and did not even respond to the second problem. You've got to do better than that to keep my membership much longer.

You are absolutely right. I wouldn't belong to any organization that was never able or willing to help me. As executive vice president, if you ask for help from the SMS staff and get no response, I want to hear about it personally. Write to me, call me, send me a FAX, but let me see what I can do for you. There will be times when the SMS will be able unable to assist you, and there will be times when you may not like the honest answer to questions you pose, but one way or another the SMS has to respond. It is

Continued on page 250

What's on your mind?

WHERE HAVE OUR creative writers gone? Share your personal experiences of special significance, your poetry, and your short stories with your colleagues through the *WMJ*'s "Soundings" feature. Of course, your "Soundings" should be related, in some way, to your being a physician.

For consideration and possible publication, send your creative writing to: *Wisconsin Medical Journal*, PO box 1109, Madison, WI 53701.❖

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board. Write to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.❖

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American Heart Association

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Continued from page 248
our sole reason for existence.

- It seems to me that Dr Todd spoke out for the big Marshfield clinic and ignored the solo practitioner interest.

First, it wasn't Dr Todd, the AMA executive, who spoke out against the lawsuit filed by Blue Cross and Blue Shield against the Marshfield Clinic, it was me--acting on the direction of the SMS Executive Committee. That action was later endorsed by the Board of Directors and the House of Delegates.

The Executive Committee determined that the decision to file the lawsuit was an extremely poor one, in that it will prove costly, pose a threat to the health of northern Wisconsin residents, and very probably have a chilling effect on the ability of small groups and solo practitioners to negotiate with the "Blues" in the future. The SMS urged the insurance company to withdraw its suit.

Second, the SMS action did not "ignore the solo practitioner interest," it tried to advance it. The SMS hopes to protect the negotiating power of *all* Wisconsin physicians. This suit will likely have anti-trust implications, because tying up the state's largest clinic in court sends the clear message to smaller clinics and solo physicians that when Blue Cross and Blue Shield presents a proposal, there is no negotiating: You play by the Blue rules or you pay the price. And how many solo and small group practices have the resources to fight the "Blues" in court?

The SMS has not commented on the merits of either side of the case, but it is saying that the courts are not the best way to solve these disputes. Blue Cross and Blue Shield should withdraw its legal action against the Marshfield Clinic, then sit down and talk through their differences so that access to high quality care can continue to be assured to all Wisconsin residents.

If the state and national medical associations do not stand up for physicians, who will? We simply cannot sit idly by and allow insurance companies to dictate to physicians their prices and terms of contracts, nor let them bully physicians with the threat of lawsuits.

- Get rid of the totally unnecessary travel information. I can't believe you use our dues to produce those glossy ads to fly to the uttermost end of the world.

Actually, we don't. Not a single SMS dime is spent on producing travel ads, glossy or otherwise. In fact, the travel companies *pay* the SMS for the privilege of presenting their ads to the SMS members. It is one more way to produce non-dues revenue, all of which lets your SMS do more for you.

Several hundred SMS members take the trips each year. The travel programs are simply another benefit that you may elect to use, but which costs you nothing as a member.

- I find it annoying that my dues are used to support candidates I do not agree with.

This one is particularly important for all SMS members to understand: *No* SMS dues dollar is used to support any candidate for public office. It would be neither ethical nor legal. The only money used to support political candidates is money donated to WISPAC and Physicians for Better Government.

- All MDs should be polled to develop a stand on an issue instead of a handful of non-working socialist MDs dictating a "stand" for everyone that is just the opposite of the majority.
- I feel the SMS is run by an "in" group.
- As a young physician, I tend to view the hierarchy of organizations such as this as "entrenched" and the "old boys" network.

The SMS has firm term limits to guarantee a scheduled turnover among leadership positions, ensure a steady supply of fresh blood in the leadership, and avoid the creation of an "in group" or an "old boys network."

I encourage you to attend a meeting of the SMS Board of Directors. The multitude of opinions, perspectives and values expressed--and the level of spirited debate--will quickly dispell any notion that the SMS is controlled by some comfortably homogeneous clique.

- I don't agree with all of SMS views.
- Stay neutral in issues where physicians will collide....
- Try to reflect the views of the membership rather than personal views. Stay away form issues where the membership is divided.

With 8,000 members, liberal and conservative, rural and urban, in primary care and specialties, in solo and group practices (as well as administration, research and academics), and of a variety of religions, ethnicities and nationalities, I think the SMS would be hard pressed to identify an issue on which physicians did not collide. Some collisions are more forceful than others, but the increasing diversity of our membership makes the search for nice, safe, "neutral" issues a less than promising mission.

You don't agree with all SMS views? Good. It would be most spooky if you did. Americans don't agree with every view of their president, every law passed by Congress, every decision made by the courts or every regulation created by government agencies--total agreement is not likely (I doubt it is even possible) in a democracy.

Fortunately, the SMS members are used to the give and take, the win some and lose some, nature of democracy. The important thing is for everyone to stay involved and make themselves heard.

- Our local society is a social club not a serious medical society. Therefore, I do not participate.

The only way for a medical society--county, state or national--to change its nature is though member involvement. Non-participation simply preserves the status quo. If you don't like the way your society functions, do something about it. Speak up. Talk to your colleagues. Encourage greater participation by physicians who share your thoughts. Take on leadership responsibilities.

Every so often, we receive letters from physicians who wish to resign in protest over some SMS position. I've never understood that reaction. By walking away, you yield the field to your foe. By quitting, by not participating, you weaken the voice within the society that speaks for your position. By maintaining your membership and enhancing your involvement, that voice is strengthened.❖

Soundings

Farewell to a friend: Morry Schroeder, MD, 1908-1994

I FIRST MET Morry Schroeder in 1950, when I was a junior medical student at Marquette. It was in the surgery lab. As one of the instructors, he was wearing a scrub suit, and certainly wasn't much to look at, even then. Already quite bald on top, he had a bright red fringe on the sides, and thick red hair on his chest and arms. If he smiled, I didn't see it.

To a junior student who found approximating the tip of a hemostat to the bleeding point a complete mystery, he was a daunting authority figure, and I felt just like those Iraqi generals must have felt when they sat across the table from Gen Schwartzkopf. I quickly put any thought of a career in surgery well behind internal medicine or pediatrics at that point, and it wasn't until my internship that I decided in favor of surgery after all.

I saw little of Dr Schroeder until I began my internship at Columbia Hospital. He had joined the Columbia staff after the war, and by 1952 was pretty well set in a routine that he was to follow throughout most of his early career--running a service at the Milwaukee County General Hospital and at the VA, using whatever time he had left over a modest private practice at Columbia, where he also taught the interns and residents surgery. His Sunday morning rounds at 09:00 at Columbia were already a ritual, about the only Sunday ritual in which he ever participated.

(Morry's aversion to church was legendary. The only time I ever saw him enter one was at Ascension Thursday mass in the cathedral at Santiago de Compostela, and he was there as a tourist to observe the swinging of the giant censer during benediction.)

For reasons still not clear to me, I decided to become a surgeon and began my residency at the VA in 1953. All Schroeder observers will tell you that he tends to leave a lasting impression on those with whom he comes into contact. With his former residents, though, that "impression" is more a "brand," seared into the skin in an area similar to that selected on a hereford or Aberdeen angus. And at the VA he ran his service year-round, taking time off only for Badger football games in Madison, the Central Surgical Society, the Clinical Congress of the American College of Surgeons and a couple of weeks in late summer to work out "up north" with the Country Day School football team. There was no escape, even for some of us clever in the art of schedule manipulation.

To make matters worse (and quite understandably, in my view), Morry was still a bachelor when I began my residency. He certainly didn't drop any hints about contemplating matrimony--probably because he knew we would try to convince Lillian of the error of her ways, but one weekend in 1953 or 1954, he did the unthinkable and showed up on Monday a married man. Some say this change to a more domestic way of life mellowed him. If so, I never saw it.

Morry's interest in athletics, although second to his interest in surgery, kept him in good condition. He played a lot of handball, did a lot of swimming, and was always organizing football games, the participation in which was mandatory, and would leave us pretty banged up. None of us was permanently

Continued on next page

Continued from preceding page
disabled, but our OR performance was not enhanced to a noticeable degree.

Perhaps the most poignant memories of that period are best expressed in this little vignette: You're the senior resident on call, and things aren't going well on the service. It's 02:00 and you know you have to telephone the attending physician. The attending is Dr Schroeder, so you know the junior resident is not allowed to make the call. You review the chart again to make sure you haven't missed anything--and then you dial.

Two rings and you hear, "Dr Schoeder." You begin your well-rehearsed presentation. He clears his throat and asks for some information you didn't consider important enough to commit to memory. He clears his throat again (that man could clear his throat more ominously than Boris Karloff) and says, "Call the OR--I'm on my way!"

Morry in the OR was not easy for a resident to endure across the table. You could feel the tension mounting, and although he would try to restrain himself, he would eventually whisper, "Jesus Christ!" But he could whisper it louder than any inspired evangelist could shout it, and he got his message across quite clearly.

But residencies do end sooner or later, and so did mine. I began practice at Columbia where Morry was then chair of the department of surgery. He was a strong leader, a bit uncompromising, but fair and completely ethical--and an excellent role model for Wisconsin surgeons.

Ed Ellison came to town in 1959, and spotted those same traits in Morry. Marquette's department of surgery had never before had a full time chair or faculty. Ed needed someone like Morry to help build his department, so he talked Morry into going full-time--probably one of the smartest moves he made in those formative years. For Morry constituted a link between the old and the new; he had the respect of the alumni, and his obvious support of the new leadership made Ellison's task a lot easier.

The '50s and '60s were the decades in which Dr Schroeder was most active in the Wisconsin Surgical Society, when such problems as fee-splitting and itinerant surgery were still prevalent in parts of Wisconsin, before there was an effective Wisconsin chapter of the ACS. His guidance in the area of ethics was a major factor in the near elimination of those practices.

In 1971, while trudging from the parking lot to the stadium for a Packer's game, Morry experienced severe angina. Within a few days Dudley Johnson had performed coronary artery bypass grafts, and after a complicated course Morry was back at work much the same as before. This chain of events was repeated several times for arteriosclerosis-related problems, and he always snapped back. In recent years, however, failing sight had been a severe handicap, and he was no longer able to get around well because of it.

There are Schroeder-trained surgeons scattered all over the country, all of whom undoubtedly have fond memories of Morry--probably fonder now than they were at the time of creation. But we are all better because of the time we spent with him and we will all miss him.

--Wayne J. Boulanger, MD
Milwaukee❖

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Culture and medicine

THE *WISCONSIN MEDICAL JOURNAL* is seeking articles from Wisconsin physicians on the subject of cultural diversity in medical practice. If you are serving a significant minority patient base, or are studying the delivery of health care to minority populations, please consider submitting a paper on your findings to the *WMJ* for possible publication in a special issue.

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Letter

Lyme disease and Hippocrates

To the editor: What end will be served by "universal health care" if insurers refuse to cover, and therefore doctors spurn treatment of, the ill?

For example, currently the battle over Lyme disease is artificially bifurcated. One fraction posits the irrelevance of costly long-term treatment; the other promotes its necessity. The former conveniently asserts if the patient is not cured with short-term treatment, the malady is not Lyme disease. Concurrently, this group alleges some Lyme disease patients may never fully recover. Applied logic does not allow the simultaneous holding of these two mutually exclusive positions. One opinion must be false; both may be. Moreover, they are, indeed, merely opinions.

Hippocrates stated, "(t)here are in fact two things, science and opinion; the former begets knowledge, the latter ignorance."

Lyme disease has presented a quagmire of issues, none of which are resolved. The current objective is not to arbitrarily divide, but to conquer the disease through lucid rumination and scientific study. To this end, it is again instructive to look to Hippocrates. He is oft misquoted as stating, "first do no harm."

The actual quote does not provide this comfortable escape veiled in pseudo-altruistic nonfeasance. Rather, he taught, "(a)s to diseases make a habit of two things—to help, or at least, to do no harm." Thus, the charge is to be proactive and provide assistance. Alternatively, as an obvious minimum level of care, avoid inflicting collateral injury and harm. It should be noted, however, leaving people to suffer, merely based on opinion or sheer ignorance, is a great harm.

The clarion call derived from medical ethics demands the elimination of the capricious and contemptuous tactical division, as well as the treatment with available measures and an active pursuit for a means to conquer Lyme disease.

—Steven D. Reske, Esq.
Minneapolis❖

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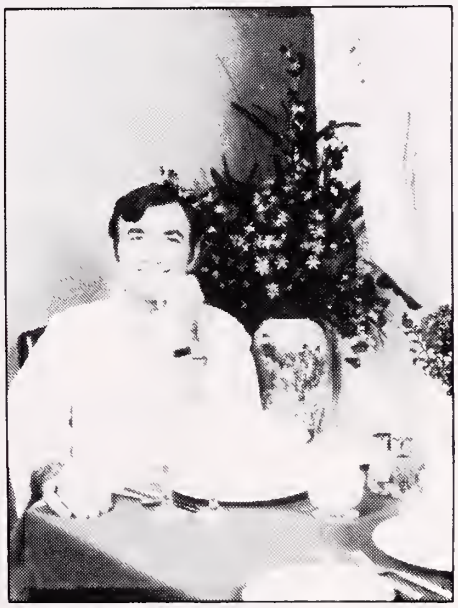

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CARE

Lead in breast milk: Should mothers be routinely screened?

Laurie Tellier, MS, RN, and Richard A. Aronson, MD, MPH, Madison

THE PREVENTION OF childhood lead poisoning has been the focus of numerous recent public health initiatives. As knowledge about the effects of lead on the health of children has increased, the threshold for a safe blood lead level has decreased. In October 1991, the Centers for Disease Control recommended lowering the childhood blood lead level of concern from 25 ug/dL (micrograms per deciliter) to 10 ug/dL.[1]

Lead-based paint is clearly the most widespread and toxic source of environmental lead exposure for infants and young children. There exists, however, the possibility that an infant could be exposed to lead through the mother's breast milk. This paper reviews current information on lead in breast milk to answer the question of whether breast feeding mothers should be routinely screened for blood lead.

Tellier is a nurse consultant with the Bureau of Public Health, Wisconsin Division of Health. Dr Aronson is the chief medical officer for maternal and child health for the Wisconsin Division of Health. Reprint requests to: Laurie Tellier, Bureau of Public Health, 1414 E Washington Ave, Rm 112, Madison, WI 53703. Copyright 1994 by the State Medical Society of Wisconsin.

Toxicology of lead

Lead is widespread as a result of industrialization. Lead has no known physiologic value. Even low levels of lead can have harmful effects on a child's developing central nervous system, kidneys, and hematopoietic system. At high levels in children (greater than 80 ug/dL), lead poisoning can result in convulsions, coma, and death.[1]

About 2% of the total adult body burden of lead is found in the blood, in red blood cells. Another 3% of the body burden of lead is found in the soft tissues of the brain, kidneys, and bone marrow. The majority (95%) of the lead in the body is stored in bone and teeth. The half life of lead in blood and soft tissue is about 30 to 40 days; the half life of lead in bone is 20 to 30 years.[2] Lead stored in bone can be mobilized during times of physiologic stress, including growth, pregnancy, and lactation, and move into the soft tissues and blood. Lead is similar in many aspects to calcium; lead and calcium compete for absorption in the gastrointestinal tract and deposition in bone.[3]

Lead in breast milk

The concentration of lead in breast milk is dependent on maternal blood lead levels. The transfer of any substance in the maternal blood to breast milk is related to that substance's solubility and binding affinities. Transfer from blood to breast milk is favored for chemical substances that are nonionized, alkaline, lipid soluble, low molecular weight and that are not tightly bound to red blood cells or other proteins in the blood.[4]

Several variables inhibit the transfer of lead into breast milk: lead is an ionized (electropositive) metal; lead is tightly bound to the red blood cells; and plasma levels of lead are normally only 5% of the total maternal blood lead.[5]

The milk-to-plasma ratio gives a relative indication of the amount of a chemical in breast milk compared to the amount of that chemical in the mother's blood. Any substance with

Table 1.--Milk-to-plasma ratios.

Substance	Ratio
lead	0.2:1
iodine	65:1
nicotine	2.9:1
PCBs	3-10:1
ethanol	1:1

Adapted from: Wolff M. Lactation. In: Paul M, ed. *Occupational and environmental reproductive hazards: A guide for clinicians.* Baltimore, Md: Williams and Wilkins; 1993;66.

a milk-to-plasma ratio equal to or greater than 1:1 can be assumed to result in a significant dose to the infant.[6] The milk-to-plasma ratio of lead is 0.2:1. This means that little of the lead in the mother's blood will be transferred into the breast milk. Table 1 compares the milk-to-plasma ratios of some other substances.

The half life of a chemical gives a relative indication of the length of time a chemical would be present in breast milk after a specific timed exposure (Table 2). This concept is often used when evaluating the effect of a dose of a specific medication or a poisoning incident. Lead has a long half life in breast milk because lead stored in bone can be mobilized, move into the blood, and become available for transfer into breast milk.[7] The very low milk-to-plasma ratio of lead means that although lead could be present in breast milk for a relatively long period of time, it will be present in very small amounts.

Studies measuring lead in breast milk in the general population have shown a decline over time in mean lead levels from 2 ug/dL (100 cc) of breast milk to 0.1 ug/dL. [4,8] These averages have been influenced by the mother's lifetime environmental exposure to lead. This also means that the mother's current residence (urban v rural) is not likely to be a factor in her current level of lead in breast milk. It is believed that the decline in mean lead levels in breast milk corresponds to the decline in general population blood lead levels, most likely due to the decreased use of leaded gasoline.[1]

There is no laboratory in Wisconsin set up to do routine analysis of lead content in breast milk. For more information, health care providers can call the State Lab of Hygiene (608) 262-1146 (Toxicology).

Infant consumption of lead

The amount of lead in breast milk will be relatively stable over the period of nursing.[9] For example, a 5 kg (11 lbs) infant would consume an average of 700 cc (24 oz) of breast milk per day. Using the more recent, lower mean amount of 0.1 ug per 100 cc of breast milk, this results in a daily dose of 0.7 ug of lead. This would be considered a low level of dietary lead intake as compared to the continuing FDA Total Diet Study, which estimated in 1988 that infants' total lead intake from food, water and beverages was approximately 5 ug per day.[5]

In general, commercially prepared "ready-to-feed" formula has been found to contain similar amounts of lead as in breast milk. Concentrated or powdered formulas that require dilution would reflect the lead content of the water used. If the tap water had a high lead content, the infant could receive a substantially higher dose of dietary lead from formula than from breast milk. Because lead present in tap water is usually a result of lead in the plumbing system, it is recommended that the water run for 2 to 3 minutes before being used for food or formula preparation.[10]

Conclusion

Lead is widespread and will always be present in breast milk to some extent. The total amount of lead in breast milk is stable over time and is determined by the mother's lifetime exposure and body burden of lead. The contribution of lead in breast milk to infant body burden is small and is less important than prenatal and other postnatal exposures.

Thus, we conclude that routine blood lead screening of breast feeding mothers to determine infant risk is not necessary. The benefits of breast feeding outweigh concerns about infant exposure to lead from breast milk.

Table 2.--Half life of chemicals in breast milk.

Substance	Half life
lead	13 weeks
iodine	20 hours
nicotine	1.5 hours
PCBs	5 to 8 months
ethanol	3 hours

Adapted from: Wolff M. Lactation. In: Paul M, ed. *Occupational and environmental reproductive hazards: A guide for clinicians.* Baltimore, Md: Williams and Wilkins; 1993;66.

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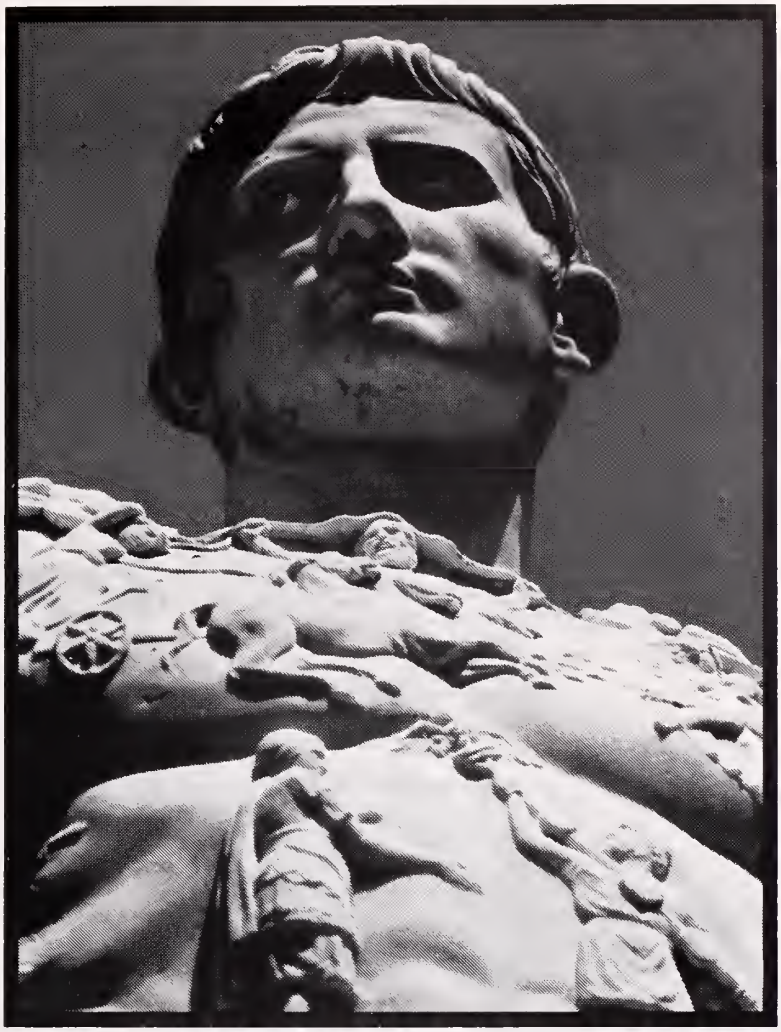

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Takayasu's arteritis: a report of three cases

Sharmishtha Raikar, MD, and Shereif Rezkalla, MD, Marshfield

Takayasu's arteritis is a rare disease seen mainly in young Oriental women. We report three cases of Takayasu's arteritis seen in our clinic. All three involved white women, and the ages at diagnosis were 18, 24, and 46 years. The diagnosis was confirmed by arteriography. Prednisone therapy produced marked improvement in signs and symptoms. Takayasu's arteritis is an important diagnosis to consider in young women with postural dizziness and with absent or diminished pulses.
Wis Med J.1994;93(6):261-263.

TAKAYASU'S ARTERITIS is known by various eponyms like pulseless disease, aortic arch syndrome, idiopathic aortitis, reversed coarctation and Martorell's syndrome. It was first described by Savory and Kussmaul in 1856.[1] In 1908, Takayasu[2] described the ocular manifestation of the disease, consisting of a wreath like arteriovenous anastomosis around the papillae and cataracts.

Initially thought to be limited to the aortic arch and its branches, Takayasu's arteritis is a chronic inflammatory arteriopathy of unknown etiology affecting large vessels. Recent streptococcal infection, antiaortic antibodies, and genetic predisposition have been implicated, but the etiology remains obscure. Ueno et al[3] have subdivided the disease into three types. Type I involves primarily the aortic arch and its branches; Type II spares the aortic arch, involving the thoracicoabdominal aorta and its branches; Type III combines features of both. Lupi-Herrera et al[4] have suggested a fourth category, Type IV, in which there is pulmonary arterial involvement. We are reporting three cases of Takayasu' arteritis.

From the department of cardiology, Marshfield Clinic, Marshfield, WI 54449
Reprint requests to: Shereif Rezkalla, MD, Marshfield Clinic, 1000 N Oak Ave, Marshfield, WI 54449. Copyright 1994 by the State Medical Society of Wisconsin.

Case 1

An 18-year-old woman had postural dizziness on getting up from the sitting or supine position. She also had dyspnea on exertion. Physical examination revealed absent carotid and upper extremity pulses. A harsh systolic murmur was present over the precordium, which radiated to the neck and back. Sedimentation rate, C-reactive protein and immunoglobulins were moderately elevated. Two-dimensional echocardiography showed left ventricular hypertrophy. Doppler echocardiography showed a 110 mm Hg pressure gradient across the aortic arch. Arteriogram and electromagnetic resonance imaging showed progressive narrowing of the aortic arch, thickened wall, severe stenosis of the

Fig 1.--Electromagnetic resonance imaging of the chest showing narrowing of the aortic arch and thickening of the aortic wall (arrow), courtesy of Dr T. Gallant, Marshfield Clinic.

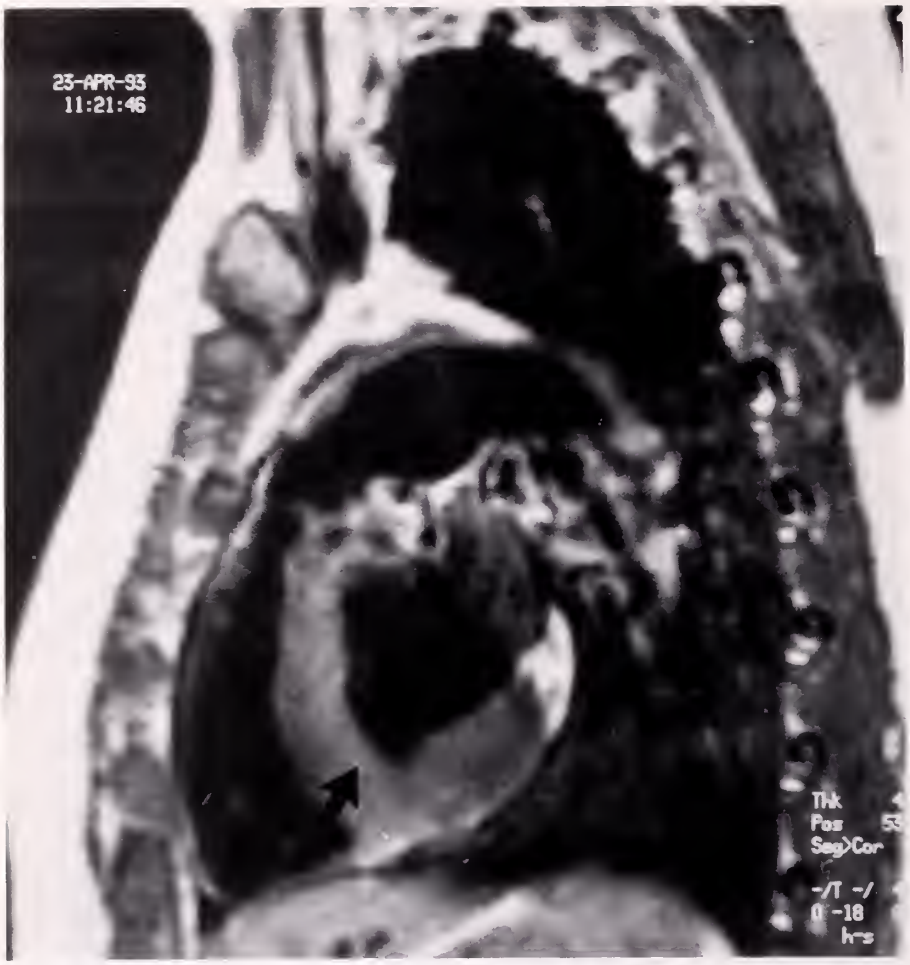

Fig 2.--Electromagnetic resonance imaging of the chest showing marked hypertrophy of the left ventricle (arrow), courtesy of Dr T. Gallant, Marshfield Clinic.

brachiocephalic artery and complete obliteration of the left common carotid and the left subclavian (Figs 1 and 2). While electromagnetic resonance is not essential in establishing the diagnosis, it helps in operative planning if surgical correction is considered.

The patient was started on Prednisone and the symptoms improved, including a 60 mm Hg reduction in transaortic gradient. Despite improvement in transaortic gradient, the patient still was left with a significant gradient that will cause an extra burden on her left ventricle. The pathophysiology will be similar to significant aortic stenosis, and surgical correction is being considered.

Case 2

A 46-year-old woman had tingling in her arms, headaches, and visual aura. Arteriogram and a CT scan of her chest confirmed Takayasu's arteritis.

The patient was started on Prednisone, the dosage of which was tapered over the next 8 months, with complete resolution of her symptoms.

Case 3

A 24-year-old woman had fever, right sided pain, dizzy spells, and left scapular pain on exertion. She had bilateral absent radial pulses and aortic regurgitation. The sedimentation rate was elevated at 128. Arteriography showed occlusion of both subclavian arteries in the axillary region and enlargement of the ascending aorta, suggestive of an aortic aneurysm. A biopsy of the occluded axillary artery was diagnostic of Takayasu's arteritis.

The patient was prescribed Prednisone for 2 months. The dosage was gradually tapered over the next several months, and both radial pulses returned. The patient underwent aortic valve replacement for aortic regurgitation.

Discussion

On review of literature, Takayasu's arteritis has been extensively reported from the Orient and Mexico. Systemic systems like malaise, fever, palpitations, weight loss, and dyspnea are common in Takayasu's arteritis. They were reported by Nakao et al[5] in their series. Asthenia and dyspnea were present in 70% of the patients reported by Lupi-Herrera et al.[4] Arthralgias, numbness and fever predominated in the series reported by Hall et al.[6] All or most of these symptoms were present in our patients. Increased sedimentation rate and gamma globulins were universally present in most series.[4-6] A synopsis of the salient clinical features and laboratory findings is depicted in Table 1.

Few clinical syndromes may mimic Takayasu's disease. Granulomatous arteritis may have similar changes, usually in the subclavian, axillary, brachial, and femoral arteries; yet it is usually seen in the elderly. Congenital coarctation of the aorta will show gradient across the descending limb of the aortic arch; yet the narrowing is localized. Also in coarctation of the aorta, because the narrowing occurs just after the origin of the left subclavian artery, pulses are normally felt in the upper extremity, but diminished in the lower extremity.

Pulse deficits or absent pulses seen in two of our patients are the most significant physical findings reported in patients with Takayasu's arteritis. Numbness and headaches

have also been reported. The arteriographic findings in our patients were characteristic of Takayasu's and all three had a good response to steroid therapy.

Steroid therapy usually continues until symptomatic improvement occurs and sedimentation rate normalizes. Patients having disease progression while on steroid therapy may be controlled with cyclophosphamide.

The prognosis is variable, depending on response to therapy and the presence and severity of complications. Patients with a stable, controlled course have a reported 6-year survival rate of 98%, while those with a complicated course have a survival rate of 55%.[7]

Postural dizziness, seen in cases I and III, is an important symptom and only one study[6] has reported this before. Takayasu's arteritis must always be excluded in young women with postural dizziness and absent or diminished pulses. Awareness of the disease leading to early diagnosis and treatment may prevent complications and decrease morbidity.

Salient features of Takayasu's arteritis.

Article	No. of cases	Symptoms	Signs	Laboratory findings
Nakao, et al[5]	84	Malaise fever palpitations SoB†	Hypertension	Leukocytosis ESR* globulins CRP††
Lupi-Herrera, et al[4]	107	Asthenia weight loss SoB	Pulse deficit vascular bruits hypertension headaches abnormal fundi arthralgias	ESR globulins positive Mantoux (2 TU)
Hall, et al[6]	32	Arthralgias numbness fever postural dizziness weight loss headache	Vascular bruits absent pulse hypertension	ESR globulins EKG abnormalities

* ESR = Erythrocyte sedimentation rate.
† SOB = Shortness of breath.
†† CRP = C-reactive protein.

Acknowledgements

We are indebted to Thomas Gallant, MD, for his valuable and expert assistance in electromagnetic resonance. We also thank Doreen Luepke for excellent secretarial assistance.

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Survival 13 years after pancreatectomy for ductal adenocarcinoma of the head of the pancreas

Eugene E. Eckstam, MD, Monroe

THE LITERATURE CONTAINS reports of eleven 10-year survivors[1-10] and this report adds a 12th. A report must differentiate between true ductal adenocarcinoma of the head of the pancreas and other malignancies, such as ampullary, endocrine or common bile duct malignancies, to be included. There are good general reviews on adenocarcinoma of the pancreas[4,11,12] and management of the diabetic state.[13]

Literature review

Most pancreatic cancers arise in the head. Sener,[14] in a report by 88 Illinois hospitals on 2,401 patients, found 69% in the head, 21% in the body and 10% in the tail of the pancreas. I found no separate 3- and 5-year survival rates for cancers of the body and tail. The few survivors are individually identified, as are all 10-year survivors.

The survival rates fall rapidly the first year after diagnosis, then taper off. There are no 5-year survivors of patients with ductal adenocarcinoma without resection. The average 5-year survival rate found in collected series is about 6%, with a range from 0 to 30%. The latter are patients that were operated on recently and had radical and extended radical resections.

The extent of pancreatic resection is not standardized. Pancreatic resection appears to mean a traditional resection, removing nodes that are easily available. Radical resection appears to mean extensive removal of lymph node bearing tissue over a wide area and extended radical resection appears to mean additional removal of involved portions of adjacent organs and major vessels.

Early symptoms are abdominal pain, anorexia, jaundice, and diarrhea. Early diagnosis is aided by a high index of suspicion and the early use of ultrasound, computerized tomography, magnetic resonance imaging, endoscopic retrograde cholangiopancreatography, percutaneous transhepatic cholangiography, and fine needle aspiration.

The 11 cases found in the literature are summarized in Table 1. Some of these patients are reported in other articles published by the same institution but by different authors.

Materials and methods

From 1973 through 1988, 125 patients were explored in St Clare Hospital because of jaundice or a suspected pancreatic lesion. Forty-six had some type of procedure other than a simple biopsy. Of these, 38 had some form of bypass and 8 had a Whipple resection. One patient had a total pancreatic resection and he is the only patient that lived longer than 3 years.

In 1980, St Clare Hospital had about 200 beds. Monroe is a town of about 10,000 people located 40 miles south of Madison Wis. The Monroe Clinic is a 50-physician multispecialty group that makes up most of the staff of the hospital. The Monroe Clinic serves as a referral center for southern Wisconsin and northern Illinois. All surgeons are board-certified or eligible and all types of surgery are done except cardiac surgery and neurosurgery.

Illustrative report

A 52-year-old man had three days of jaundice and itching. He smoked two packages of cigarettes a day and had increasing dyspnea and coughing. He developed insomnia, fatigue, craving for cold nonalcoholic liquids, food and acid regurgitation, and low back pains accom-

Table 1.--Pancreatic resection: 10-year survivors.

Case	Year	Author	Surgery	Survival years	Living
1	1984	VanHeerden	Total?	19	Y
2	1987	Christ	Whipple	11	Y
3	1987	Connolly	Whipple	12	Y
4	1990	Trede	Total?	10	Y
5		"	Radical Total	11	Y
6	1990	Manabe	Whipple	12	?
7	1991	Botello Romero	Total	12	Y
8	1991	Nakagawa	Extended Radical	10	Y
9		"	" "	10	Y
10		"	" "	15	Y
11	1991	Allison	Whipple?	10	Y
12	1994	Eckstam	Radical Total	13	Y

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panied by foul smelling, watery, yellowish-white stools. His liver was 3 cm below the right costal margin.

Laboratory results were: total bilirubin, 4.6 mg percent; direct bilirubin, 2.1 mg percent; alkaline phosphatase, 610 mg percent; serum glutamic oxaloacetic transaminase, 129 mg percent; cholesterol 378 mg percent; and a positive antibody response to hepatitis A virus.

Ultrasound showed a dilated gallbladder. Endoscopic retrograde choleangiopancreatography identified a concentric narrowing of the distal common bile duct. From the ampulla of Vater distally for 3 cm, there was absence of filling of the ascending main duct except for side branches. The body and tail filled normally. The pancreatic ductal system emptied rapidly through the accessory duct of Santorini, whereas the biliary system remained filled. Carcinoma of the head of the pancreas seemed the most likely cause.

Preoperative preparation consisted of central vein hyperalimentation, intensive respiratory and ambulatory therapy for 5 days. On Oct 20, 1980, at exploration, a 3-cm movable mass with no sign of spread was found in the head of the pancreas. The results of a trans-duodenal deep wedge biopsy proved a diagnosis of carcinoma of the pancreas and a radical total pancreatectomy was done.

An en bloc resection consisted of the distal third of the stomach, entire duodenum and upper 6 inches of jejunum, gallbladder, common duct, pancreas, and spleen. A portion of lateral spleen remained to keep partial immunity. The dissection removed all fat and lymphnode bearing tissue from the retroperitoneal fascia and vessels. A complete vagotomy was done and the esophageal hiatus was repaired anatomically to prevent an iatrogenic hiatal hernia.

Intestinal reconstruction consisted of a retrocolic vertical posterior gastro-jejunostomy, which allowed for straight passage of food and gastroscope. Staplers were used for anastomoses and these were oversewn with catgut to prevent bleeding. To avoid bile reflux gastritis, an end to side hepatic duct-jejunostomy was made 60 cm distally. Beyond this, a Witzel jejunostomy was placed for tube feedings. Triple lumen sump drains were placed in each upper quadrant and a small catheter was placed in the pelvis. Permanent buried retention sutures of polypropylene, placed only in the musculo-fascial layers, and a secondary type of wound closure were used to prevent wound dehiscence and infection. Six units of packed red blood cells were used during the operation, which lasted 4.75 hours.

Table 2.--Enzyme content at various pancrease capsules.

Enzyme	Pancrease *12/day*	MT-10 *8/day*	MT-16 *6/day*
Lipase	48,000 U	80,000 U	96,000 U
Amylase	240,000 U	240,000 U	288,000 U
Protease	300,000 U	240,000 U	288,000 U

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The next day the hematocrit was 0.55, and it stabilized at 0.37.

Immediately postoperatively, central vein hyper-alimentation, antibiotics, aggressive respiratory care, and ambulation were continued. A solution of 0.5 g of neomycin sulfate and 10,000 units of bacitracin in 100 mL of saline was instilled into the pelvic catheter every 4 hours for 3 days. Intermittent low suction was applied to the upper abdominal triple lumen drains.

Diabetes was controlled with diet and using regular and long-acting insulin, as needed. One or two capsules of Pancrease (Pancrelipase, McNeil Pharmaceutical) were given with each enteric feeding and subsequently with each of his six daily meals. More than 10 capsules per day caused cramps and diarrhea.

In 1989, because of decreasing weight, he was placed on the new Pancrease MT-10 (pancrelipase MT-10, McNeil Pharmaceutical) capsules, one at each of the six daily meals and an extra capsule with larger meals. They contain proportionally more lipase as seen in Table 2. These capsules are more expensive but are easier to take and have fewer side effects. He gained weight and his insulin requirements increased due to better use of food.

He returned to part time work in 6 weeks and full-time work in 12 weeks. Because of work-related stress, he had trouble controlling his diabetes. He retired after 3 years, reversing this trend. The only diabetic complication has been a gradual decrease of touch sensation in his toes. Currently, he is active in volunteer community affairs and reports that he is happy to be alive. He willingly accepts his diabetic status.

The final pathology report was a well-differentiated adenocarcinoma, locally invasive, with a small focus near the ampulla. Because of the rarity of a patient surviving 5 years after resection for cancer of the pancreas, the tissue was re-examined and sent to another widely known institution for re-evaluation. The original diagnosis was confirmed as an infiltrative pancreatic ductal adeno-carcinoma, grade two or three on the basis of four grades. There were microscopic peripancreatic extensions into fat and there was also extension into the ampulla of Vater.

Discussion

In 1978, Remine[15] was the first surgeon to report three patients living more than 5 years following pancreatic resection for ductal adenocarcinoma of the head of the pancreas. Because he was not satisfied with the results of a Whipple resection of the pancreas, he changed to total pancreatectomy. It was his report that influenced my decision to use a total pancreatectomy. It is likely that one of his patients is the first 10-year survivor reported in 1984 by van Heerden,[1] also of the Mayo Clinic.

Several factors influence long term survival. The biological makeup of the cancer and the stage of the disease at the time of surgery are the primary determinants of a patient's longevity, therefore, early recognition and diagnosis are important. We do have some control on patient survival by devoting proper attention to the nutritional status, mobility, extent and preciseness of the operation, as well as the care with which complications are prevented and treated.

Preoperative preparation with intravenous and oral hyperalimentation is stressed in some reports.[3,11,16] If given for 7 to 10 days, it will help slow nitrogen loss and allow for correction of electrolyte and fluid imbalances. Continuation of hyperalimentation immediately after surgery may stop nitrogen loss and possibly reverse the trend.

Careful attention to operative technique[6,17,18] and regional lymph node dissection[9,19,20] appear to aid long term survival rates. Nagakawa[9] has three 10-year survivors and he recommends an extended radical resection with complete stripping of the retroperitoneal areas and vessels. If necessary, he resects the vessels. If the lesion is confined to the head and the margins are free, he will leave the distal quarter of the pancreas.

Trede[5] has two survivors, and he "skeletonizes" the retroperitoneal structures.

Manabe's results[6] suggest "that radical surgery with a sufficiently wide free margin around the cancer is indispensable."

These three authors have six of the 11 10-year survivors and they stress radical, regional resections with total pancreatectomy, if needed.

Avoidance of complications is important.[2,9] The most common complications are wound infections, gastrointestinal blood loss, intraperitoneal abscess, wound dehiscence, pulmonary embolus, and fistulas. Usually, these complications can be minimized or avoided following the technical details outlined in the illustrative report.

Summary

In dealing with a lethal disease such as cancer of the pancreas, an all out attack is necessary for an early lesion. The general trend seems to be toward radical en bloc resections, usually, but not always, with a total pancreatectomy. A digestive supplement with a higher proportion of lipase provides better nutrition. Diabetes can be controlled in patients with no pancreas. Reports of long-term survivors should be better documented as to details of previous reporting, care, procedure and pathology.

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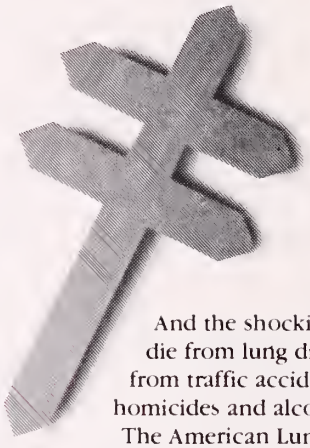

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Clarifying goals, improving communication, and finding joy in the doctor-patient relationship

Randy Maigaard, MD, and David Schiedermayer, MD, Milwaukee

THE DOCTOR-PATIENT relationship in the United States is complex, as illustrated by the following anecdote. When you tell a French person that death is imminent, he or she says, "Oh, if only I could speak the language for a while longer! If only I could see the Champs Elysees again." When you tell a British person that he or she is going to die, the person says, "Oh, if I could just see the coast again, the white cliffs of Dover!" When you tell an American that he or she is going to die, the person is likely to say, "I want a second opinion! I want a transplant! I want the spelling of your last name!"

On his late-night TV show, comedian David Letterman might list the top 10 frustrating things about the current doctor-patient relationship as follows:

10. The words "policy wonks" being used favorably.
9. I would like to request my client's chart.
8. Does this medicine really work?
7. My other doctor gave me penicillin for a cold.
6. Please sign this order for home oxygen.
5. Please draw another HDL, my last one was normal.
4. You need to get pre-authorization approval.
3. This is the new assistant associate hospital administrator.
2. My teeth itch.
1. Here is a complete list of symptoms I've had for the last 5 years.

In this article, we would like to focus on clarifying the goals of the clinical encounter, improving doctor-

Continued on next page

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patient communication, and finding and keeping the joy in medical practice. We will use a patient case from one of our practices to help illustrate these points.

The case

Patient X is a 45 year-old woman with a history of rheumatoid arthritis who has been under the care of a rheumatologist. The arthritis has been in remission. She is given to somatization, and has developed a benzodiazepine addiction.

In the last 5 years, she has developed a "pressure" in her head, which she says is bothersome when she stands up or walks around. Before she saw me, (RM) she saw perhaps 10 to 15 physicians, including an neurologist and an ENT specialist.

Patient X gives her history in a rambling, non-focused fashion, and she has "maladie du papier," bringing in a 20-page list of her problems and encounters with physicians. She also documents every physician encounter, notes the exact date, and describes her feelings about the encounter. She writes her doctors were "withholding information," "abrupt," "did not look me in the eye," and "mean."

By her report, the pain is all over her head, occurs daily, begins soon after waking in the morning, is mostly posterior and around the vertex of her head, and is present throughout the day. She denies nausea, vomiting, photophobia, phonophobia, or drowsiness. Her headaches are relieved by valium and codeine and have been evaluated extensively since 1991.

Patient X is an anxious, teary-eyed, woman accompanied by her husband. The patient dominates her husband despite her health problems. A physical examination found nothing remarkable.

The following tests had been done and the results were normal: MRI and CT of the head, carotid doppler, and temporal artery biopsy.

In 1991, a lower extremity EMG was obtained for subjective paresthesia, which revealed a mild peripheral neuropathy; the patient is convinced that her other physicians have been withholding information from her and that she actually has some severe disease, such as ALS. A neurologist confirmed that these findings were consistent with rheumatoid arthritis rather than a new severe disease. I repeated an EMG, and it showed minimal diagnostic evidence of neuropathy.

I have been seeing her at least once a month, and have provided multiple sessions of counseling and reassurance. Exasperated, I finally sent her to another neurologist. Patient X said the visit was a complete disaster and that the doctor brushed her off (although he spent more than an hour with her.)

The patient is adamant about not returning to a psychiatrist. She has a home health remedy book and has read extensively on neuropathies and knows every cause and wants to talk about these causes each time she comes in. Despite extensive discussion of the causes of her neuropathy, she is still not convinced that I am telling the truth.

She was hospitalized for a major depressive disorder, placed on Buspar, Zoloft, and Trazadone, all of which she discontinued after her release from the hospital.

On every visit, I feel like saying, "Look, it's time to shake it off and move on with your life."

I see her on schedule, but she always chooses Friday afternoon, and I cringe when I see her name on the list.

In this case, it is important to clarify the goals of the clinical encounter: What should we aim for with Patient X? How can we improve the doctor-patient communication? And how can we keep the joy in medical practice when we see someone like this on our schedules for Friday afternoon?

Clarifying the goals

The central responsibility of clinicians is to use technical expertise to respond to a patient's request for help by:

- accurately diagnosing the patient's condition;
- informing and educating the patient about the condition--including its prognosis if treated or untreated--and about the various possible treatment alternatives;
- recommending the course of action that the clinician considers the best technical approach for that individual's problem; and
- carrying out with technical skill those procedures (for example, further diagnostic studies or treatment) that are required by the approach chosen by the patient or, if the patient cannot choose due to incompetence, those procedures that are in the patient's best interest (and are consented to by an appropriate surrogate).[1]

In Patient X's case, we have done sufficient tests to know that the neuropathy is not progressive or clinically significant, but it has been difficult to recommend any successful treatment, even including psychiatric treatment. That is one of the reasons the clinical encounter has not been satisfactory.

In making a recommendation about clinical care, physicians evaluate the individual patient in terms of:

- the seriousness of the condition in an organic sense;
- the seriousness of the condition in the patient's

eyes;

- the need for urgent action;
- the possible therapeutic benefits;
- the potential risks of the intervention;
- alternative courses of action and inaction;
- the physical, psychological, and social effects on the patient of all options;
- the ability of the patient to participate in his or her own care; and
- the patient's values, beliefs, self-understanding, fears, and hopes.[2]

In Patient X's case, the condition is not serious in an organic sense, but it is serious in her eyes. No intervention is planned, but the patient's values include directing her medical care and obtaining a lot of medical attention for any given problem.

Finally, clinicians are called on to reach a clinically and morally appropriate decision--one that is suitable for the particular person they are treating and is based on clinical judgment.[3-6]

There is no single goal of medicine: In the encounter between patient and clinician, many appropriate goals are pursued simultaneously. But it is important that the doctor clarify which goal(s) he or she is pursuing at any given time. These goals include:[7]

- restoration of health;
- prevention of disease;
- the relief of symptoms (including physical distress and psychological suffering);
- the restoration of function or the maintenance of compromised function;
- the education and counseling of patients regarding their condition and its prognosis;
- the saving or prolonging of life; and
- avoiding harm to the patient in the course of care.

In Patient X's case, we can pursue prevention, symptom relief, and avoiding harm. We can screen her for preventable disease with mammograms, Papanicolaou smear tests, and give her flu shots. We can use benzodiazepines judiciously, and continue to try to counsel her, although she does not agree with education and counseling. And we can avoid harming her with unwarranted procedures.

In general, patients and clinicians both regard the ideal of a clinical encounter to be the identification and successful treatment of an entirely curable condition. This is not possible in Patient X, and for many of our patients like her. This explains the frustration we feel in treating her. She is a complex patient, the kind of patient who seems to sap our energy and any benevolence which we have left at the end of the day.

Improving communication

Primary care physicians can improve the care of patients like Patient X through more careful use of language. Dr Eric Cassell notes that he can help patients with their diseases by giving them power.[8]

Take, for example, a patient with cancer in the liver. We can take the patient's diseased liver and "put it over there," apart from her: words like "that liver," "it," "the," while we say to the patient, we can "keep you in control," "you're getting better," keep you on top of things."

"Given an ominous reality," he says, "we can still work in the world of language, in the world of subjectivity, and we can be remarkably effective even after our technical intervention fails."

So we can take Patient X's EMG findings or her weakness and somehow give her control over it by speaking of it as being under her control.

Lipp defines respect for patients as "an expression of understanding of other people, a recognition of their significance. an affirmation that what they say and do and think and experience matters to you and that you care about what happens to them and how they feel about it."[9]

Lipp writes:

"So much of improved function depends upon treasured trifles which cannot all be anticipated or

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Ron Richmond, MD, joined the CompHealth locum tenens medical staff when he completed his residency. He wanted to travel. He loves to meet people. A little time off sounded really good. And he thinks being exposed to different types of medical practice will serve him well when he returns to his hometown to establish a community health center.

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placed on a protocol, eg, the extra quarter inch on a stump prosthesis that eliminates pelvic tilt, reduces low back pain and makes ambulation tolerable, or the smuggled aspirin at the hospitalized patient's bedside for self-medication when the overworked nurses can't bring analgesics punctually. Some of the details patients can learn from us, some from other patients, some they can only discover by themselves. What is important is that we help establish an atmosphere in which such exchange of information and such discoveries are facilitated. How do we accomplish that? No one can do it alone. but an empathetic understanding of what it is really like for one human being to suffer from a certain type of affliction is a reasonable point from which to proceed."

The joy of medicine

We have tried to clarify the goals of the encounter with Patient X, and we have tried to work on listening to what she is really saying and respecting her as a person. How do we stay sane while we are doing all this?

Dr Robert Rowntree described his encounter with a patient like Patient X. The patient said to him that he wouldn't be able to help her, that no doctor in 10 years had done anything but take her money, and she lifted up her shirt to display a number of scars, each a failed abdominal surgery according to her. Rountree reports that he said, "You know, I think you're right. I honestly don't think I'm going to be able to help you. And I certainly don't want to join the list of doctors who have taken your money and failed to do you any good. There will be no charge for coming in today. Goodbye."[10]

He went outside the room and wondered what had happened to him. How had he gotten this far from his idealistic view of practice?

Rowntree went to a seminar on doctor-patient communication and learned some practical helps. A good seminar is that given by the American Academy on Physician and Patient, founded by Mack Lipkin, Jr. (Information on upcoming seminars can be obtained from Penny Williamson, 4611 Keswiek Rd, Baltimore, MD 21210; 410-889-1550.)

Rowntree also attended a physician support group. He lists the following principles:

- Set your priorities in life (what are core values).
- Take care of yourself first (get enough sleep, eat right).
- Get in touch with yourself (psychotherapy, medication, faith).
- Learn to say no (many doctors have superhuman self-expectations; patients like Patient X take time; limit weekend work; take vacations).
- Share your feelings (start support groups).
- Lighten your load (share professional chores).
- Learn to listen (ask open-ended questions--practice with a videotape).

Rowntree's angry patient with all the abdominal scars never came back, but he is now hoping that she will. He feels better and is more ready to treat challenging patients than he was before. Similarly, we can be ready when the Patient Xs of our own practices return. We will clarify the goals of treating her, understand the communication we have with her, and above all, keep our sense of joy in medicine as we treat her.

Patient X is a test case, in a sense, of how we are each doing in practice, precisely because she is the patient with a long list of problems who comes in on Friday afternoons.

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Self-reporting of Papanicolaou smear tests among women after hysterectomy

Katherine M. Kvale, PhD; Patrick L. Remington, MD, MPH; and Paula M. Lantz, PhD, Madison

In Wisconsin, the death rate from cervical cancer declined from 8.5/100,000 in 1960 to 2.2/100,000 in 1992,[1] a change primarily attributable to the emergence of widespread Papanicolaou smear testing. Current guidelines, recommend annual Papanicolaou smear tests for all women who are sexually active or over the age of 17. After three or more consecutive, satisfactory, normal examinations, Papanicolaou smear tests may be administered less frequently at the discretion of the woman's health care practitioner. The US Preventive Task Force recommends discontinuing Papanicolaou smear testing at age 65 if previous tests have been consistently normal.[2]

Guidelines for Papanicolaou smear testing, however, do not address whether women who have had a hysterectomy should continue having Papanicolaou smear tests. The purpose of this report is to assess self-reported Papanicolaou smear testing by hysterectomy status among women in Wisconsin.

Methods

The data presented are from a telephone survey of Wisconsin women conducted in 1993 to assess the rates of and barriers to breast and cervical cancer screening.

Random digit dial sampling techniques were used to select women 40 years and older residing in eight rural counties (Crawford, Iowa, Jackson, LaFayette, Price, Richland, Rusk, and Taylor).

A total of 2,393 women were surveyed by the Wisconsin Survey Research Laboratory (the response rate was 76%). Data on the 2,379 women with known age were used in this analysis. The data were analyzed using Statistical Packages for the Social Sciences (SPSS) and Epi-Info software.

Results

Generally, women were highly aware of the Papanicolaou smear test. Most women in the survey (99%) had heard of the Papanicolaou smear test; 95% reported having had a Papanicolaou smear test, and 61% had had a Papanicolaou smear test within the past 3 years.

The table displays rate of hysterectomy by age. Overall, 29% of women reported having had a hysterectomy with the highest hysterectomy rates in women older than 60. Time elapsed since surgery varied by age. Women over the age of 50 (29%) generally reported that their hysterectomies were more than 10 years ago, and 96% of the women in all age groups reported that their hysterectomies occurred more than 3 years ago.

Self-reported hysterectomy status for women in eight rural counties in Wisconsin, 1993.

Age	No.	% Reporting hysterectomy
40-49	694	18%
50-59	527	29%
60-60	535	35%
70-79	442	38%
+80	181	36%
Total	2,379	29%

The figure presents the percent of women who had a Papanicolaou smear test in the past 3 years by hysterectomy status. It shows that the proportion of all women who reported having a Papanicolaou smear test in the past 3 years decreased with age. It also shows that for all age groups over 40, women with hysterectomies were about one fourth less likely to report having had a Papanicolaou smear test than women who have not had a hysterectomy (relative risk = 0.76, 95% confidence limits 0.71, 0.82). About 55% of women with a hysterectomy more than 3 years ago reported having had a recent Papanicolaou smear test, compared with 75% of women without a hysterectomy.

Comment

We assessed self-reported screening practices among women residing in rural Wisconsin counties to detect current practices among health care practitioners. The results

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The public health column is not reviewed by the *WMJ* editorial board. Kvale is an epidemiologist in the Chronic Disease and Health Promotion Section, Bureau of Public Health, Wisconsin Division of Health. Dr Remington is chief medical officer of the Chronic Disease and Health Promotion Section, Bureau of Public Health, Division of Health. Lantz is a senior researcher at Marshfield Medical Research and Education Foundation, Marshfield Medical Center. This study was supported in part by grant number CA57014-02 from the National Cancer Institute. Reprint requests to: Katherine Kvale, Wisconsin Division of Health, 1414 E Washington Ave, Rm. 167, Madison, WI 53703. Copyright 1994 by the State Medical Society of Wisconsin

Continued from preceding page
suggest that Papanicolaou smear tests are likely to be administered even if a woman has had a hysterectomy. Health care practitioners may be doing Papanicolaou smear tests on women with hysterectomies for the following reasons: the woman had a sub-total hysterectomy and still has a cervix; the hysterectomy was done for a malignant condition; or as a screening test for vaginal cancer.

No information was available on the reasons that women had a hysterectomy in our study. Nevertheless, it is likely that a minority of these women have an intact cervix or had surgery for cancer. Since the 1960s, the "total" hysterectomy, which includes removal of the cervix, has been commonly practiced; before the 1960s, many women had "sub-total" hysterectomies and the cervix was left intact.[3] In one study of elderly women with hysterectomies in New York City in 1985, one third of the women had an intact cervix.[4] In addition, previous studies have shown that 11 percent of hysterectomies are for cancer.[5]

Practitioners do not have guidelines and there is no clear consensus on screening for vaginal cancer among women who have had a total hysterectomy for a benign condition. The most recent technical bulletin of the American College of Obstetricians and Gynecologists states that: "The cost-effectiveness of cytologic screening for vaginal neoplasia after removal of the cervix for benign disease has not been demonstrated. In consideration of the low risk of preinvasive vaginal lesions or invasive cancer, however, periodic cytologic evaluation of the vagina, based on the patient's risk factors, is suggested."[6]

In contrast, a Canadian task force advises: "Women do not need to be screened if they have never had sexual intercourse or have had a hysterectomy for benign conditions with adequate pathological documentation that the cervical epithelium has been totally removed and previous normal smears have been normal."[7]

The lack of consensus guidelines and disagreement among practitioners leaves a gray area for women and practitioners regarding whether a woman with hysterectomy should be screened for cervical cancer.

The US Preventive Services Task Force may address this issue in its upcoming review. In the meantime, health care practitioners should examine a woman to see if she has a cervix and know the reason for the hysterectomy. If a woman has had a sub-total hysterectomy, or a hysterectomy for cancer, Papanicolaou smear testing is currently recommended. In contrast, cancer screening among women who have had had a total hysterectomy for a benign condition, has not been shown to be cost-effective.

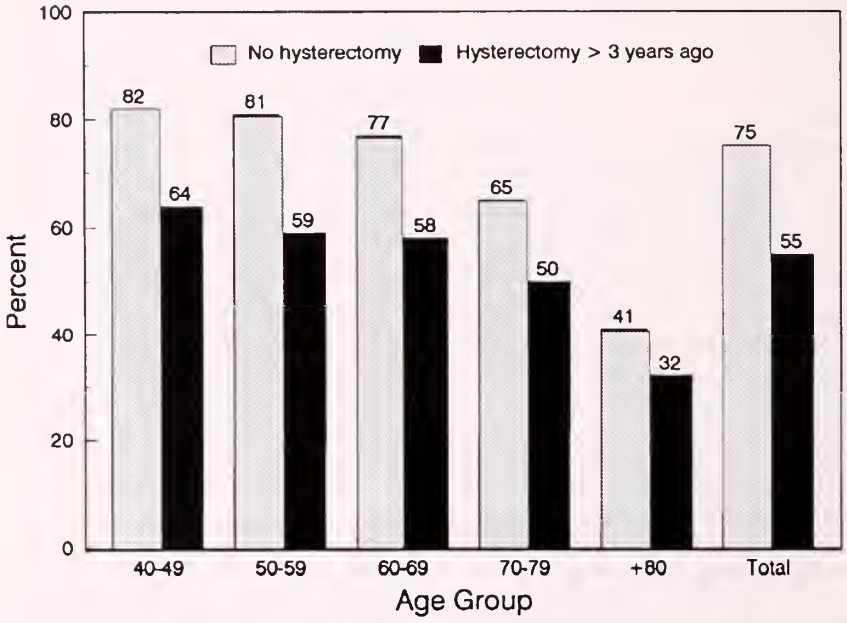

Fig--Percent of women who have had a Papanincolaou smear test in the past 3 years, Wisconsin, 1993.

Acknowledgements
The authors thank Donna Knutson, CHES, James Parker, and Mathew Reeves, PhD, for providing technical assistance.

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AMA unveils legislative initiative to protect patients

THE AMA has unveiled a new legislative proposal, the Patient Protection Act, to guarantee that patients and their physicians--rather than insurance companies--make decisions about patient care.

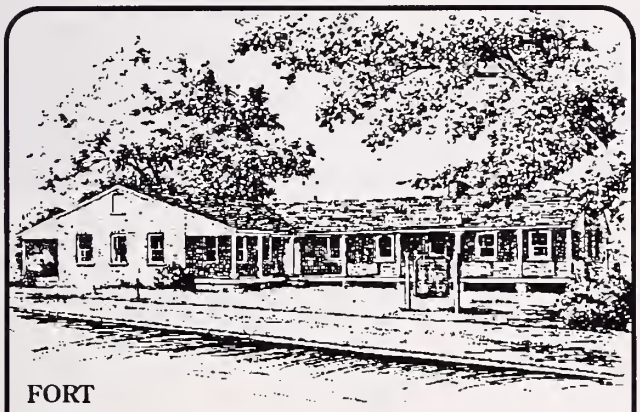
"Patients should no longer be subject to the `health insurance lottery," said Lonnie Bristow, MD, chair of the AMA Board of Trustees. "They should never be surprised to discover that their insurance doesn't cover their health care needs, their regular doctors can no longer treat them or they won't be allowed access to the specialty care they need.

The proposed Patient Protection Act would provide patients with the following:

- a list of covered services describing exactly what the plan pays for;
- a list of exclusions telling patients what they need to pay for themselves;
- clear instructions on whom to call before medical treatment is rendered;
- survey information on how other patients feel about the health plan;
- a choice of three plan options: HMO or PPO, traditional insurance plan, or a benefit payment schedule (plans pay exact dollar amount for any service; patient and physician then decide on payment between themselves); and
- access to a point-of-service plan to have the opportunity to pay extra to see a physician outside the regular plan.

In addition, the AMA says all health plans should be required to:

- give physicians a voice in medical policy-making;
- continue relationships with all physicians who give patients the care they need;
- provide physicians with an essential role in developing criteria to ensure quality patient care; and
- disclose to physicians information about those reviewing their work.❖



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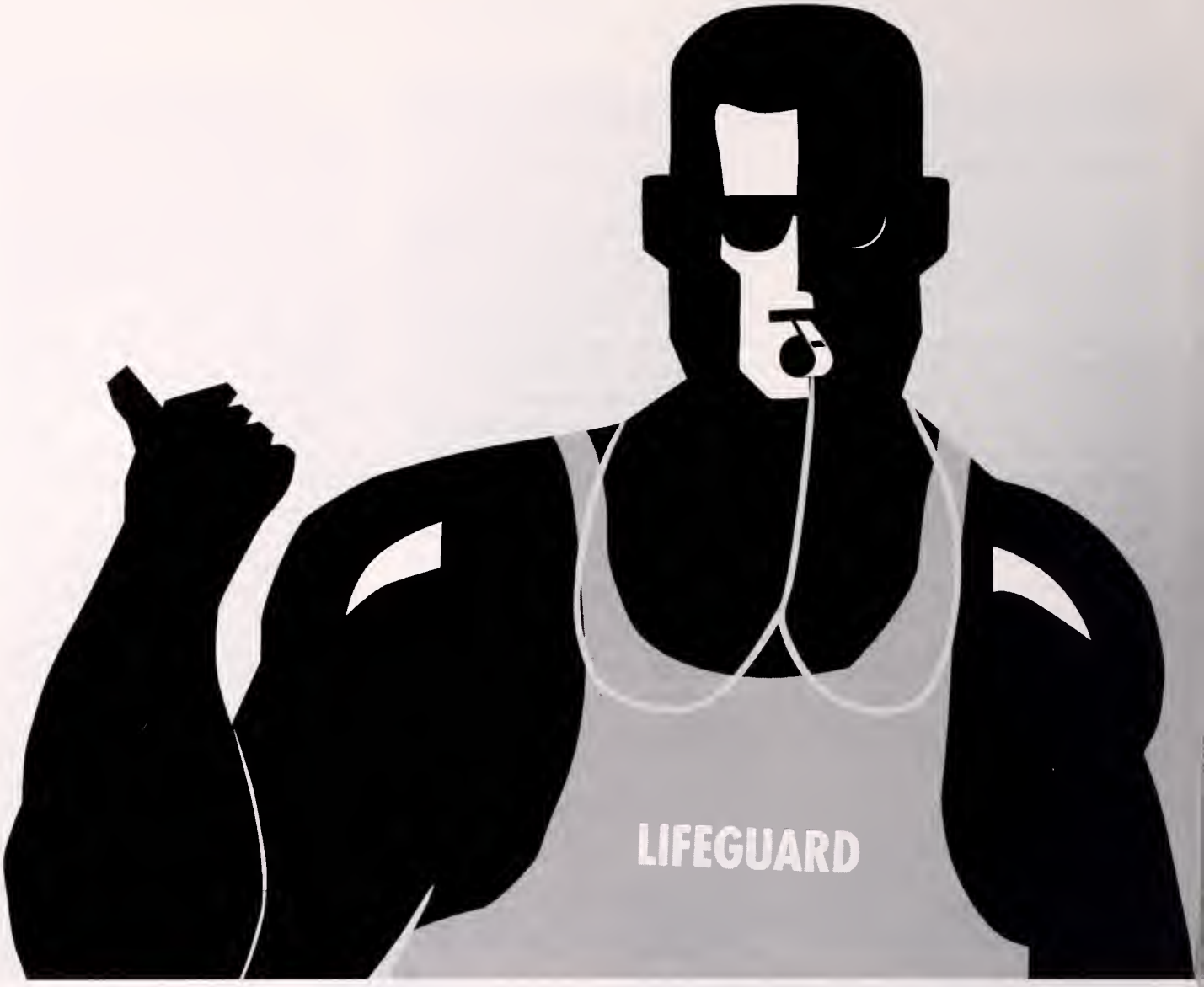

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A glimpse into our past

Richard D. Sautter, MD, medical editor

A couple of years ago, during the SMS 150th anniversary, I provided a monthly column of tidbits drawn from the history of medicine and the SMS in Wisconsin. It was met with some interest and amusement, so I hinted--as the anniversary drew to a close--that I would revive it at some future date. Well, here it is. I hope you have as much fun reading it as I did writing it.

25 years ago

It's now a matter of life and death: "Only licensed physicians and registered pharmacists may sell contraceptives.... In no event may such article, drug or preparation be sold to any unmarried person. Prohibited also is the advertising or public display of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives...." A violation could cost $500 and 6 months in jail.

Another legal notice: "The Wisconsin Legislature has added LSD ... to the list of dangerous drugs ... which may be used by or distributed to the general public only when prescribed by a licensed physician or other person authorized by law." Illegal use of possession could cost $500 or 1 year in jail.

A persistent shortage: The SMS held a conference to address Wisconsin's "doctor drain" and resulting physician shortage. A medical student asserted that "young people are turned off by medicine today;" a physician said that health quackery in Wisconsin was "a block to physicians coming here" and proposed legislation to "outlaw chiropractic;" and a hospital administrator urged doctors to be more productive, saying that a 5% increase by all doctors would have the effect of producing 14,000 new doctors.

Help wanted: "General practitioner for 4-man mixed group; central Wisconsin city of 20,000; salary $20,000, future partnership, no investment."

50 years ago

War time ad in the WMJ. "Courageous as he is versatile, the war doctor fulfills long, tough missions without thought of rest. When it's time to relax, he keenly appreciates the pleasure of a good smoke--Camel, most likely, the favorite of the armed forces--for sheer mildness, friendly taste. Make it your pleasure to remember those you know of in the services. Send them cartons of Camels often! Camel--costlier tobaccos."

Loss of virility? An editorial by a former SMS president graded organized medicine's performance harshly. "Where organized medicine has failed so consistently during its recent years of conflict has not been through any important lack of clear thinking among its members nor in any want for capable and progressive leaders. Rather, we have been shoved around badly of late simply because we have lacked the hardiness of effort that is so much required of any interest or group in these rough and tumble times if it is to prevail. Even now, in the very face of attack by most powerful and revolutionary forces, medical societies everywhere may be seen complacently relegating their military men to a limbo of honored absentees who, paying neither tribute nor service, no longer interest themselves in organizational affairs. What labor union would let a full fourth--the youngest, most virile fourth--of its membership sift through its fingers in that fashion?"

Compulsory sickness insurance. A push for national health insurance in the 1940s led the *WMJ* to compare Wisconsin health statistics with those from nations having national health insurance: infant deaths per 1,000 live births stood at 31.9 in Wiscon-

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sin, 52.0 in England, and 60.0 in Germany; maternal deaths per 1,000 live births were 17.0 in Wisconsin, 39.0 in England, and 48.0 in Germany; deaths from diphtheria per 100,000 population was 0.16 in Wisconsin, 7.2 in England, and 10.9 in Germany; deaths from pneumonia per 100,000 population was 39.1 in Wisconsin, 72.0 in England, and 88.1 in Germany; and male workers in Wisconsin lost only 4 days of work per year due to illness, compared with 12 days for male workers in England, and 18 days in Germany.

Medical progress extends life. The *WMJ* published a chart showing that the average age at death in Wisconsin had reached 60.5 years--up from 40.0 years in 1910. The average age at death had increased every year, except during the influenza epidemic of 1918-1920, when the average dropped from 44.8 in 1917 to 39.3 in 1918. Modern life expectancy in Wisconsin is now over 75 years.

75 years ago

Gun down a meal. The makers of Puffed Wheat, Puffed Rice, and Corn Puffs explained that "in our puffing process the grains are sealed in guns. The guns are revolved for 60 minutes in a heat of 550 degrees.... Then the guns are shot, and a hundred million steam explosions occur inside each kernel. Every food cell is thus blasted and the grains are puffed to bubbles eight times normal size.... You will agree, we believe, that these are the ideal forms of grain food where ease of digestion is in question. And never were grain foods made so enjoyable." They sold for 15 cents each, "except in Far West."

Besides, it's the right thing to do. The maker of Quaker Oats countered with the claim that its product "comes close to a perfectly balanced food. It is one sixth protein and very rich in minerals.... Quaker Oats yields 1,810 calories per pound. It is over twice as nutritious in calorific value as round steak. It costs 5 cents per 1,000 calories. Meats, eggs, fish and fowl costs from 40 to 50 cents per 1,000 calories. Each large package of Quaker Oats used to displace meat on a calory basis saves about $2."

Amen to that. A 1919 *WMJ* reminded its readers that "This journal is yours. You make it. If it is to be better, you must make it better. The scientific articles are yours. They cannot be better than you write. The news is news of your activities. The editorials are comments on your interests. Every one of is concerned in a better journal. Let us all help by writing better papers, by reading our ads, patronizing our advertisers, by keeping up better local societies, by being better secretaries, more active health officers, and the most conscientious doctors and patriotic citizens of which we are capable."

Sign of the times. The *WMJ* ran the following poem without naming the poet:

My Tuesdays are meatless,
My Wednesdays are wheatless,
 I'm getting more eatless each day;
My house it is heatless,
My bed it is sheetless--
 They've gone to the Y.M.C.A.
The barrooms are treatless,
My coffee is sweetless,
 Each day I grow poorer and wiser;
My stockings are feetless,
My trousers are seatless--
 My gosh! but I do hate the Kaiser.

100 years ago

Memoranda for the annual meeting. The SMS advised its members that "The experience of the last meeting more than ever shows the necessity for short, pithy, practical papers, so that there shall be time to listen to a large number (and) that an opportunity shall be given for thorough discussion, usually the most interesting and profitable part of the meeting.... All papers should be typewritten, properly punctuated and paragraphed."

The scientific papers offered in 1894 were on "Chronic Interstitial Nephritis--five papers.... Pus in the Pelvis--four papers.... Traumatic Lesions of the Brain--five papers.... Sympathetic Ophthalmitis--six papers... Tuberculosis in Early Life--three papers...." and "Mucous Nasal Hypertrophies--five papers."

Imported epidemics. The SMS "memorialized Congress to effect speedy changers in the methods of disinfecting ... rags which are exported to our shores." The SMS noted that "In three of more instances, within the last four months, has small pox occurred at papermills in the interior of the state among operatives whose business it was to handle imported rages.... In the United States alone, there have been 74 epidemics of small pox caused by the importation of undisinfected rags, and (studies show) that their disinfection in foreign ports is now, and always has been, only a shameful pretence."

Disease prevention has always been a hard sell. The SMS president wrote that "Judging from newspaper articles that have recently appeared in its denunciation, we are led to believe that the popular mind is becoming prejudiced against vaccination to an extent, which, in view of a possible epidemic of small pox, is somewhat alarming.... I see no reason what a vaccine establishment should not be a state institution and under the supervision of a physician selected by the state Board of Health, by reason of his fitness for the work, and not because of his political opinions. Such a recommendation from this Society would be likely to receive favorable consideration at the hands of our next legislature."

Bullets don't kill people, headaches kill people. A physician delivered a pa-

per on brain injuries, in which he enumerated four categories of "suicidal shots": "1. Ball lodged in the substance of one brain hemisphere. 2. Ball traversing both hemispheres and landing in opposite wall of the skull. 3. Same conditions, but ball turning back and lodging after recurring course in brain substance. 4. Ball passing clear through." And, in what must still reign as the champion medical understatement of the past century, he noted that "All injuries are followed by headache, which if severe and unchecked, develops into encephalitis, coma and death."

125 years ago

An early attempt at cost containment? In addressing the annual meeting, the SMS president remarked "I tell you, gentlemen, this all absorbing one idea of money, this morbid hankering after the almighty dollar, the *auri sacrafames* has had a masterly influence and a telling effect in the procurement and spread of empirical practice, and in fixing on the fair fame of medicine, the mildew of ultraism and speculative assurance. Indeed, from this sickening weakness and this excessive desire "to have and to hold" may be traced quackery in all its vulgar and nude deformity, and all its odious and contemplative dissimulations."

The Phoenix rises. On June 16, 1869, the Wisconsin State Medical Society convened after a lapse of more than 6 years. The Society had been suspended during the Civil War. Its revival was planned at a 1867 meeting in Janesville and brought to fruition 2 years later in Madison. Or, as it was stated at the time: "The fires that were well nigh extinguished by the leaden respiration of Mars, and the demoralizing influence of belligerent strife, are again sending forth, from altars dedicated to medical science, the light of truth, the warmth of regeneration, and the incense of a professional covenant."

An early MEB. The Society tabled a committee report that recommended the creation of an SMS board of examiners to license ("issue a diploma") "all persons, hereafter locating in the state, for the purpose of practicing medicine and surgery." The committee insisted that "no candidate under 21 years of age shall be admissible for examination" and that "the recipient of the diploma shall pay $20" to defray the examiners' travel expenses.

A light turns on. Dr Charles Stoddard, of East Troy, delivered a paper at the SMS annual meeting and proclaimed: "Among the many discoveries which are now lighting our paths and shedding such blessing on humanity, none can claim, in my estimation, as high a rank as the discovery of the vaso motor nervous system, which must henceforth become the great beacon of the therapeutist. For it is evident from some arrangement of the great apparatus which it controls, directly or indirectly, must necessarily come all the evils that flesh is heir to; congestion stasis, inflammation, and spasm of blood vessels, all being governed by its various states of pathological or functional derangement."❖

New members appointed to restructured SMS commission

The SMS House of Delegates earlier this year approved the restructuring of the Commission on Safe Transportation as the Commission on Injury Prevention and Control. The commission will consider issues and recommend public safety measurers for reducing the incidence of injury or untimely death resulting from gun violence, domestic abuse, transportation accidents, fires, drowning and falls.

The SMS board has appointed Thomas Luetzow, MD, an emergency physician in Waukesha, to chair the commission. In addition several new commission members have been named. Among them are: Frederick Blanke, MD, of Madison; Richard Ellis, MD, of Middleton; Kevin Fullin, MD, of Kenosha; Robert Jones, MD, of Racine; Larry La Crosse, MD, of Mequon; Bernard Micke, MD, of Madison, and Joanne Selkurt, MD, of Whitehall. ❖

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Physician briefs

The * indicates a member of the SMS.

J. Evan Blanchard, MD,* has joined the internal medicine staff of Physicians Plus-Jackson Clinic in Madison.

Thomas P. Driscoll, MD, has been named senior vice president for medical affairs at St Joseph's Hospital. He has served for 20 years as an active member of the St Joseph's Hospital medical staff as an internist specializing in endocrinology.

Louis J. Iorio, MD,* has joined the orthopaedics department of Physicians Plus, specializing in surgery of the foot and ankle. He is located in the Quisling Clinic in Madison.

Rex Kolste, MD,* a board-certified family medicine physician, has joined the staff of Mercy Clinic South-Center for Family Medicine in Janesville. Dr Kolste earned his medical degree from the University of Nebraska Medical Center in Omaha, Neb, and completed his family practice residency at Wesley Medical Center in Wichita, Kansas.

Daniel McCarty, MD,* professor of medicine at the Medical College of Wisconsin, has been honored by the Wisconsin State Assembly on his long and eminent career as a leading national and internal rheumatologist.

Susan Mickel, MD,* has been selected to receive the Wisconsin Alzheimer's Information and Training Center's 1994 professional award, honoring her for making a significant contribution in Alzheimer's care and issues. Dr Mickel is a Marshfield Clinic neurologist.

Myron Mikaellan, MD, an orthopaedic surgeon, has joined the medical division of All Saints Healthcare System, Inc., in Racine. He is a graduate of the Medical College of Wisconsin.

Thomas R. Perry, MD,* a neurologist with the Monroe Clinic, has accepted a clinical affiliation with the department of neurology at the University of Wisconsin Medical School. Dr Perry has been with the Monroe Clinic since 1992. He earned his medical degree at UW.

Ann C. Smith, MD, a dermatologist, has joined the staff of Marshfield Clinic. She earned her medical degree from the University of Colorado School of Medicine in Denver. She served her residency in dermatology at the University of Iowa College of Medicine in Iowa City.

Govindaraju Subramani, MD,* has joined the Ripon Medical Center. Dr Subramani was certified by the American Board of Internal Medicine in 1987 and has completed a cardiology fellowship, serving at both Wright State University and the University of Wisconsin Hospitals in Madison. He also completed a residency in internal medicine at Mt. Sinai Hospital in Chicago.

Fredy Toiber, MD, will join the staff of Internal Medicine and Family Practice Clinic in Sturgeon Bay Aug 1. Dr Toiber is completing his residency at the University of Wisconsin in critical care and pulmonary medicine, and has already completed a residency in internal medicine.

Sridhar V. Vasudevan, MD,* has been appointed medical director for the Center for Pain Medicine at Community Memorial Hospital in Menomonee Falls. This center will provide consultation services to patients with pain after acute injuries and post-operative pain as well as cancer-related pain. In addition, it will provide a multi-disciplinary functional rehabilitation management for patients with chronic pain. Dr Vasudevan in clinical professor of physical medicine and rehabilitation at the Medical College of Wisconsin. He is a past president of the Midwest Pain Society, the American Academy of Pain Medicine, the American College of Pain Medicine and the Wisconsin Society of Physical Medicine and Rehabilitation.

B.K. Wasiljew, MD,* of Mercy Clinic East in Janesville, has been inducted into the Society of Surgical Oncology. ❖

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County society news

Brown. The Brown County Medical Society held a meeting May 12, 1994, at the Holiday Inn City Center. Neva Kaye, chief of the DHSS managed care section, was the speaker. New members accepted into the society were: Dennis J. Bielke, MD; Linda S. Gemer, MD; Carol E. Parker, MD, Robert K. Patrick, MD; and Mary M. Rajala, MD.

Dane. The Dane County Medical Society approved membership for John Blachard, MD; Calvin Bruce, MD; Anne Champeaux, MD; Carl D'Amato, MD; Louis Iorio, MD; Julie Nielsen, MD; David Queoff, MD; and Nitzet Velez, MD.

Kenosha. The Kenosha County Medical Society approved membership for Efraim Gelbard, MD; John C. Noonan, MD; and Goro Tsuchiya, MD.

Marathon. The Marathon County Medical Society approved membership for Leo K.L. Young.

Milwaukee. Emmett J. Doerr, MD; and Daniel M. Begel, MD, have been accepted for membership in the Medical Society of Milwaukee County.

Monroe. The Monroe County Medical Society approved membership for Rodney A. Erickson, MD; Laurie A. Logan, MD; Emile W. Salvo, MD; and John J. Smalley, MD.

Outagamie. New members accepted into the Outagamie County Medical Society include: Robert E. Garrett, MD; Mark B. Hallett, MD; Joseph R. Lamb,MD; Caroline J. Lundell, MD; Elizabeth M. Mitchell, MD; Lars G. Ostman, MD; Maurice J. Pare', Jr., DO; Robin T. Price, MD; and Manuel A. Rivera, MD.

Richland. Allen Schawe, MD, has been approved for membership in the Richland County Medical Society.

Waukesha. The Waukesha County Medical Society approved membership for Roger W. Beaumont, MD; and David Avino, MD.

Winnebago. The Winnebago County Medical Society met May 5, 1994, at the Robbins Restaurant in Oshkosh. Dr John Hein gave a lecture on lake flies. New members accepted into the society are: Felipe Patino Ambas, MD; Milhgros Roque Cuaresma-Ambas, MD; and Robert Bruce Devermann, MD.❖

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- Authors are encouraged, whenever possible, to submit manuscripts on computer disks, using IBM-compatible software. Electronic submissions are also possible. A printed copy must accompany all disk and electronic submissions.
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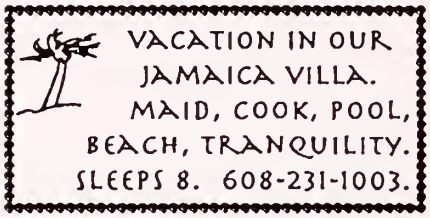

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State Medical Society of Wisconsin

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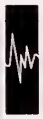

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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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Contents

July 1994 Vol. 93 No. 7

Opinions

295 *President's page*
The rough riders of reform
by Richard G. Roberts, MD, JD, Madison
298 *EVP report: The view from here*
Peeling onions under the summer sun
by Thomas L. Adams, CAE, Madison
300 *Letters*
AMA recruiting effort draws more fire
by Glenn A. Smith, MD, Two Rivers
And still more
by Thomas N. Rengel, MD, Wausau
Kudos for the new president
by R.M. Hammer, MD, River Falls
An added resolution
by Russell Lewis, MD, Madison

Organizational

303 SMS officers and directors: 1994-1995
316 SMS resource directory
321 SMS commissions and task forces: 1994-1995
330 Officers of Wisconsin's county medical societies
335 Officers of the SMS specialty and special sections
339 Officers of Wisconsin specialty societies
342 Publications available
345 Statewide Physician Health Program
346 WISPAC and Physicians for Better Government
348 SMS physician support program
349 Mediation and peer review services
350 Accreditation program for continuing medical education
351 Membership facts
353 SMS officers and directors by district
356 Expense reimbursement policy and procedure for physicians on SMS business
357 SMS financial report
358 Charter law of the SMS
359 Constitution and Bylaws

Contents

Annual meeting

369 1994 House actions on resolutions and reports
373 House of Delegates Nominating Committee: 1994-1995
374 *Presidential address*
A great flame follows a little spark
by Pauline M. Jackson, MD, LA Crosse
375 *Address of the president elect*
Children, gun violence and the healing community: Wisconsin physicians together making the difference
by Richard G. Roberts, MD, JD
378 *EVP report to the House of Delegates*
Crazy times demand crazy organizations
by Thomas L. Adams, CAE, Madison
381 Awards given by the SMS in 1994
384 Reference committees: 1994

CES Foundation

386 A CESF guide to gifts
387 CESF facts
388 CESF history
389 Foundation grant allocation
390 The Fort Crawford Medical Museum

Organizational

393 SMS headquarters gain new security system
394 Physician briefs
395 County society news
395 Obituaries

Our cover: SMS President Richard Roberts, MD, JD, demonstrates that physician leadership is vital to the health of our communities in a number of ways. See page 375.

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Seymour I. Schwartz, MD, FACS
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Director, Assembly Department

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President's page
The rough riders of reform

Six US presidents since Teddy Roosevelt have attempted to place health care at the top of the American domestic political agenda. None before Bill Clinton has succeeded. The autumnal expectations of the 1992 presidential campaign grew into the vernal hype surrounding the 1993 President's Task Force on Health Reform. The president's stirring presentation of his plan in an address to the Congress in September 1993 riveted the attention of an American public apparently intent on change.

Then began Congressional deliberations over what many believe to be the most complex legislation ever considered by the federal government. The possibility of change gave way to the realities of politics. After nearly 2 years, the American public appears to have grown weary and anxious over the health system reform debate. And just when it was beginning to get interesting....

President Clinton's Health Security Act has provided the ruler by which the other health proposals have been measured. The Congressional wranglings over universal coverage v coverage targets, employer v individual mandates, comprehensive v basic benefits packages, and cigarette taxation rates have smacked of politics as usual and suggested partisan gridlock. Given the action to date of several Senate and House committees, it seems likely that a conference committee will be negotiating a compromise proposal early this fall.

The Senate appears to favor as little tinkering with the current system as possible--employer mandates, required regional alliances, and comprehensive benefits are not likely to clear the Senate. The House proposals address more of the president's concerns, but would build on Medicare, creating a new Part C for the uninsured. Incumbents are not eager to return to the home districts during the November campaign to answer challengers who will throw into their faces a failure to enact health reform.

Rustling outside the media fanfare surrounding the Congress have been the continued consolidation and corporatization of American health care. What has been lost on the media and the public is that health system reform is galloping forward, and faster than could ever be accomplished through governmental decree. While the doctors and public are transfixed by the legislative shootout in Washington, business managers have corralled an increasing share of the health care capacity.

Horizontal and vertical integrations, mergers and acquisitions, primary care networks--physicians increasingly are employed by, and patients increasingly receive care from, health care systems. There are advantages possible in these organizational changes: improved service for patients through economies of scale and reduced practice variability, enhanced information and management systems, and increased competitiveness.

Richard G. Roberts, MD, JD

There are also dangers inherent in these changes: decreased patient satisfaction when there is a greater emphasis on corporate profitability than patient needs or preferences,

Continued on next page

Continued from preceding page
reduced commitment to a community when health professionals are seen as interchangeable parts of a larger medical machine, and diminished professional satisfaction.

This tension between a distaste for government involvement and a distrust for corporate medicine is evident in the range of physician attitudes about health system reform. Most physicians groups have favored the incrementalist approach reflected in the various managed competition proposals.

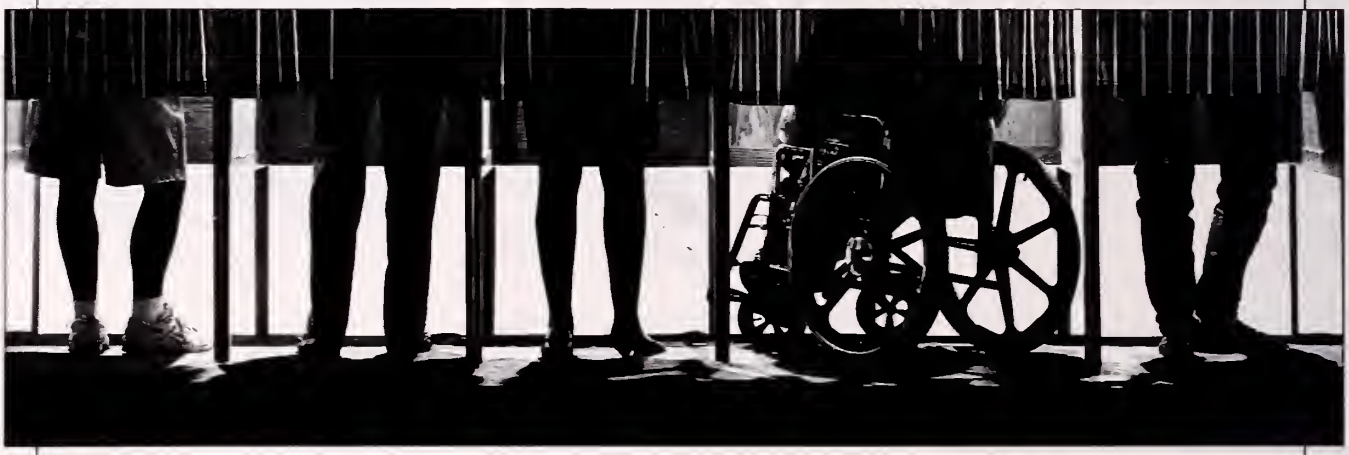
Some physician organizations, most notably the American College of Surgeons, have concluded that the least intrusion into the doctor-patient relationship and the greatest simplicity are achieved through a single payor approach.

Finally, a few physicians yearn for an era without third party payors and advocate for incentives for individual patient payments such as "medi-saver" accounts.

The vast majority of physicians remain committed to the essential elements of reform: universal coverage, insurance reform, administrative relief, and tort reform.

Physicians must be willing to stand up and speak out on our essential elements of reform. We must continue to put the needs of our patients first. As our industry matures organizationally, we must remain true to the frontier ethic: celebration of the individual coupled with a sense of community cooperation. We must resist the temptation to bet the ranch over matters of turf. Disputes over fencing in the free range become moot after the locomotive has come to town. American medicine may no longer require the same number of gunslingers and lone rangers it once had--let's just be certain, as we circle the wagons for cover, that we not shoot inward.❖

YOU DON'T HAVE TO STAND UP



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Michael Maher
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EVP report: The view from here
Peeling onions under the summer sun

PROPERTY TAX RELIEF is the hot topic in Madison this summer, as the governor and his key fiscal advisers, Jim Klauser, Mark Bugher, and Jerry Whitburn try to find $1 billion a year to fund the public schools in Wisconsin. The governor says his intent is to achieve this goal through spending cuts and without new taxes.

The problem confronting the governor, as I see it, is that every dollar currently in our state budget is accounted for--and every dollar has a constituency behind it, ready to fight for it. Medically related examples come to mind:

- $2.6 million a year for childhood immunizations;
- $5.8 million a year to UW's Department of Family Medicine and Practice; and
- $8.3 million a year to the Medical College of Wisconsin.

The SMS has fought tough legislative battles over many years to get those dollars, among others, and, no, we don't want to see them cut to fund the public schools. When you consider that the three top state funded programs--local assistance, Medicaid, and the UW--receive 78% of the state budget, or $5.8 billion, it does not leave many options when deciding where to cut.

Property taxes may seem like an odd topic of discussion for a medical journal until you examine the possible ramifications a tax shift may have on health care spending in this state. It demonstrates the importance of physician involvement in social and political issues far beyond the headline issue of health system reform. We must not forsake the battles while we're fighting the war.

The governor is not the only Wisconsin citizen with tough decisions to make. We all have to consider the options. Do we, for instance, agree with the governor that property tax relief must be paid for by cuts in spending--for programs that are all important to someone--or do we prefer increasing some other tax(es)? Are we willing to pay more or do with less? Perhaps some of both?

We also have to decide whether the property tax is, in relative terms, such a bad tax. Property taxes are currently deductible on your state and federal income taxes. Assuming you pay a 7% Wisconsin state tax, that means, depending on your income bracket, that somewhere between 35% and 45% of what you pay toward local government and schools is returned to you by the state and federal governments--not a bad return on investment. (We must be sensitive, however, to the burden of property taxes on those who have fixed incomes. If the property tax is the tool we decide to use, we need to help this group of citizens with tax breaks such as the homestead tax credit.)

Thomas L. Adams, CAE

Many physicians have nice homes and pay significant property taxes. But when you think of the kids who will go without health care, of local police and firefighters who won't be hired without state aid, or of tuition increases that will put college beyond the reach of most of our young people, you begin to wonder whether

Continued on page 300

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board. Write to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.❖

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Continued from page 298
property tax relief is worth its cost.

Some may offer the suggestion that the cuts to pay for taking the schools off the property tax bill should come from school spending. That is a choice we can make, but is it a wise one? Strong arguments are made about the value of education compared to the cost of a lack of education. With the increasing demands and global competition that our children will face as they take their places in society, in industry and business, in the arts and human services, in science and engineering--and as responsible citizens--is cutting school funding a wise choice? As Thomas Jefferson noted, "If a nation expects to be ignorant and free, in a state of civilization, it expects what never was and never will be."

Certainly, there is wasteful spending that can be ferreted out of any bureaucracy as large as the public school system. Mark Twain noted that "First God made idiots. This was for practice. Then He made school boards." Each of us may be able to point to what we consider pointless or imprudent spending in our schools, but how likely are we to find $1 billion?

The issue of property taxes is like an onion: Every time you peel back a layer, you find another layer (and the urge to shed tears gets stronger!). The complexity, however, is the very reason physicians need to think about the issue, decide where they stand, and then get involved. How we resolve the problem will affect doctors, lawyers, plumbers, and secretaries alike. We need to participate in this debate as strongly as we do in any debate on health system reform.❖

Letters

AMA recruiting effort draws more fire

To the editor: I am writing in support of Dr Geoffrey Kloster from Galesville and sent a letter to you published in the May 1994 letters to the editor section. I agree with Dr Kloster that the recent solicitation of AMA for membership dues through the SMS was quite unprofessional. When I brought this letter marked membership dues notice enclosed, return address of State Medical Society of Wisconsin, and took this to our business manager in the clinic, she said I was the third physician that morning who had brought it in and that they had already determined that this was not dues for the State Medical Society but rather for the AMA. It is quite clear to all of us that a letter from the State Medical Society of Wisconsin with large letters, membership dues notice enclosed printed on the outside is quite suggestive that these dues are meant for the SMS and not totally separate organization such as the AMA. Future collaboration of the SMS with the AMA in such a way will not be appreciated.

--Glenn A. Smith, MD
Two Rivers

Kudos for the new president

To the editor: Please extend my thanks to Dr Roberts for a beautiful portrayal of medical practice in Wisconsin. If we can truly live up to his characterizations, medicine in Wisconsin truly has a bright future. Should we, however, fail in our compassion, our common goals, challenges and dreams, we will be no different than others out there grubbing for survival.

--R.M. Hammer, MD
River Falls❖

And still more

To the editor: I approached the first 10 physician colleagues I met today with the "Membership Dues Notice Enclosed" issue raised by Geoffrey Kloster, MD (*WMJ*, May 1994). All 10 felt this wording was intended, if only slightly, to deceive the receiver of the notice. Most thought it was innocuous, two were frankly upset about it. None thought it was proper.

This certainly is not a scientific study, but probably has more valid-

Continued on page 302

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Continued from page 300
ity than the editor's note in reply to Dr Kloster which states, "...certainly there was no intent to defraud or mislead the targeted audience. No other complaint about the recruitment has been heard from the approximately 3,000 SMS physicians who received this mailing."

Does the editor imply that all the non-responders have no objection?

The AMA notice in question, if only a slight and perhaps playful misrepresentation, is being directed at the wrong audience, does not seem to be well appreciated, and certainly does not cause me to have more confidence that this body represents my interests.

The editor's note, furthermore, is more irritating than the membership dues notice itself. I am sure the intention was not to add insult to injury, but reflects an insensitivity toward the letter's author and a cavalier attitude toward the ability of intelligent physicians to recognize when they are being duped.

I would like to see the SMS and the AMA regain the integrity which once allowed these organizations to enjoy full membership and the confidence of practicing physicians. It may seem like a small point, but misrepresentations directed at us are antagonistic to this process, greatly compounded by an inappropriate "apology" and defense of the practice.

--Thomas N. Rengel, MD
Wausau

Editor's note: Additional complaints have since been registered, and the SMS has asked the AMA to clarify the wording of its future direct mail recruitment pieces. The SMS is grateful to all who brought the problem to its attention.❖

An added resolution

To the editor: In keeping with a major portion of the recently concluded annual meeting of the SMS House of Delegates, I would like to introduce a resolution, but to the editor and Editorial Board of the *Wisconsin Medical Journal*.

Whereas, "The word "gatekeeper" as applied to physicians practicing primary care is demeaning, degrading, and above all inaccurate since it implies that the physician is not always fulfilling hers or his role, namely to render the best possible care to the patient. Be it

Resolved, That the word, gatekeeper, when used to describe a physician not be allowed to appear in the *Wisconsin Medical Journal* in any article accepted for publication in a future issue.

--Russell Lewis, MD
Madison❖

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

* Bernstein, Steven Alan
Boedecker, Robert Allan
Boehme, Larry Reinhardt
* Bohlmann, Brian Jeffrey
* Brauer, Warren Allen
* Burdick, Evelyn Eileen
* Cole, Sherwood A.
* Gremmels, Frederick C.
* Hankey, Terry Lee
Holmgren, Jeffrey Paul
* Jeranek, William J.
* Liu, Lily Har
* Mazur, Andrew
* Miller, Dean Donaldson
* Neustrom, Mark R.
* Pawlak, James Ronald
Prehn, Denise Miller
* Saarinen, David Michael
* Sellers, Robert Lovell
* Simpson, Henry Jos.
* Timmermans, Peter W.
* Toohill, Robert James
* Webster, Stephen Burtis
* Wilson, Jeffrey Whitside
* Wolner, Daniel Michael❖

SMS officers and directors: 1994-1995

Richard G. Roberts, MD, JD
Madison
President
(1994-1995)

Dr Roberts was elected president elect of the State Medical Society of Wisconsin in April 1993.

A board-certified family physician, Dr Roberts is a professor in the Department of Family Medicine at the University of Wisconsin Medical School and practices family medicine in Belleville. He is on the medical staff of St Mary's Hospital Medical Center, the University of Wisconsin Hospital and Meriter Hospital, all in Madison.

Dr Roberts graduated from George Washington University Medical School in Washington, DC, in 1980. A Wisconsin native, Dr Roberts had previously earned both a bachelor's and a law degree from the University of Wisconsin, Madison. He completed his internship and residency in family medicine with UCLA-Santa Monica Hospital Medical Center and held fellowships with the American College of Legal Medicine and the American Academy of Family Physicians.

Among his many awards are: the Kellogg National Fellowship (1990-1993); White House Fellowship National Finalist, 1990; Parke-Davis Teacher Development Award (1983-1984); Mead Johnson Award (1992-1993); Allie Freed Prize in Preventive Medicine (1980); Upjohn Achievement Award (1980); Alpha Omega Alpha (1979); and Phi Eta Sigma (1972).

Dr Roberts has served on the board of directors for the medical society since 1987. He was first elected as speaker of the SMS House of Delegates, the policy-making arm of the medical society, in 1987 and served through 1993. He also serves on the American Academy of Family Physicians' Commission on Legislation and Government Affairs and chairs its Task Force on Clinic Policies for Patient Care. Dr Roberts is a past president of the Wisconsin Academy of Family Physicians.

Continued on next page

Richard G. Roberts, MD, JD

Marcia J. S. Richards, MD

Thomas L. Adams, CAE

Harry J. Zemel, MD

Pauline M. Jackson, MD

Sandra L. Osborn, MD

Michael C. Reineck, MD

Richard H. Ulmer, MD

Raymond C. Zastrow, MD

Continued from preceding page

Until recently, Dr Roberts served as the state medical society's representative on the Patients Compensation Fund and the Wisconsin Health Care Liability Insurance Plan. He is a director for Wisconsin Institute of Family Medicine, HMO of Wisconsin Insurance Company and Physicians Insurance Company of Wisconsin, Inc; is a past member of the Joint Commission on the Accreditation of Health Care Organizations task force on obstetrics; and currently serves on the Health Care Quality Improvement Initiative Steering Committee for the Wisconsin Peer Review Organization.

His many civic activities have included service as a director for the American Cancer Society; medical director of the Belleville Emergency Medical Services Unit; public health advisor and school physician in Belleville; team physician for Darlington High School; medical director for Madison YMCA Triathalon; and member of the Transitional Housing, Inc, medical advisory group on the homeless. He has served on panels for the US Agency on Health Care and Policy Research and the World Health Organization.

Marcia J. S. Richards, MD
Milwaukee
President-Elect
(1994-1995)

Dr Richards received her medical degree from the University of Wisconsin Medical School in Madison and completed an internship and a residency at University Hospitals. A board-certified specialist in radiation oncology, she is currently director of radiation oncology at St Luke's Medical Center in Milwaukee and is a past president of the Medical Society of Milwaukee County. She has also served as sec-

Continued on page 306

Everyone Out Of The Pool!

Worker's Compensation Coverage

That's what some Worker's Compensation insurers are telling clinics and physicians throughout Wisconsin. These companies want to reduce their risk by eliminating certain classes of employees and sizes of risk from their Worker's Compensation pool. In your case, this includes physicians, clinic employees, and related medical service personnel.

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Continued from page 304
retary-treasurer of the organization and is a past president of the Wisconsin Society of Radiation Oncologists. She is currently the president of the Wisconsin Division of the American Cancer Society, having served as chair of its Breast Cancer Detection Awareness Project and as a member of its board of directors and chair of the Professional Education Committee. She is also vice-president of the Wisconsin Radiology Society, and a member of the Medicare Advisory Committee. Dr. Richards has been a delegate to the SMS since 1983.

Thomas L. Adams, CAE
Madison
Executive Vice President
(1994-1995)
Thomas L. Adams was named secretary-general manager of the SMS in 1987. Adams was director of the Washington, DC, office of the American Society of Anesthesiologists prior to joining the Society in 1986 as secretary-general manager designate. Adams served as assistant executive director and lead lobbyist for the North Carolina Medical Society from 1978 until 1983, when he joined the anesthesiology group. Adams graduated from Lenoir Rhyne College in Hickory, NC.

Harry J. Zemel, MD
Fond du Lac
Treasurer
Director, District 5
(1994-1997)
Dr Zemel was first elected to the Board in 1987. He graduated from the University of Missouri School of Medicine and specializes in pathology. Dr Zemel has been chair of the Finance Committee since 1989. He is also a member of the Ad Hoc Membership Committee and was president of the Fond du Lac County Medical Society in 1979.

George R. Schneider, MD

Robert F. Purtell, Jr, MD

Thomas A. Reminga, MD

Timothy G. McAvoy, MD

Marvin G. Parker, MD

Charles E. Pechous, Jr, MD

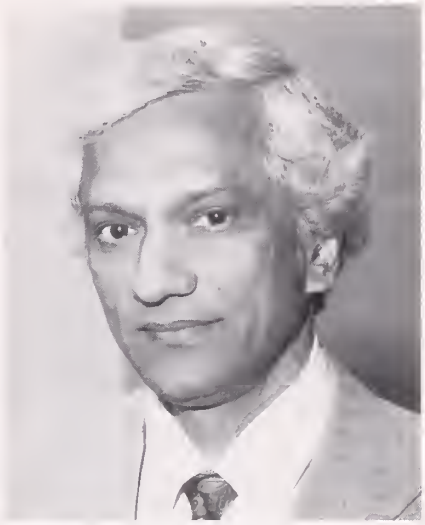
John E. Ridley, III, MD

Jay F. Schamberg, MD

Frank H. Urban, MD

Cyril M. (Kim) Hetsko, MD

Jerry M. Ingalls, MD



Ayaz M. Samadani, MD

Pauline M. Jackson, MD
La Crosse
Immediate Past President
(1994-1995)
Dr Jackson graduated from Stanford University Medical School and served her internship at Charles T. Miller Hospital in St Paul, Minn. Board certified in psychiatry, she completed her residency at the Cleveland Psychiatric Institute.

Dr Jackson has served numerous SMS committees including the SMS Committee on Mental Health from 1979 through 1992 (committee chair from 1981 to 1985), and the SMS Governmental Affairs Commission. Her many other SMS committees include the Committee on Child Abuse, Committee on Women's Issues, Committee on Alcoholism and Other Drug Abuse, and chair of the Task Force on Competition and Regulation. Dr Jackson is a past president of the La Crosse County Medical Society (1984-1985) and the Wisconsin Psychiatric Association (1987-1989).

At Gundersen Clinic, Dr Jackson chaired the Department of Behavioral Medicine from 1976 to 1987, and has served on the Board of Directors and the Medical Foundation Development Committee. She serves on the Gundersen Clinic Medical Legal Affairs Committee (since 1976) and has chaired the Medical Staff Assistance Committee at Lutheran Hospital in La Crosse. She currently serves on the Board of Directors for Physicians Insurance Company of Wisconsin.

Sandra L. Osborn, MD
Madison
Speaker, House of Delegates
(1993-1995)
Dr Osborn, whose specialty is pediatrics, graduated from the University of Wisconsin Medical School in

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Madison. She is a member of the WISPAC Board of Directors and co-chair of the SMS/WNA Committee. Dr Osborn served as president of the Dane County Medical Society from 1982 to 1983. She has also served as chair of the House of Delegates Nominating Committee, the Credentials Committee and the Reference Committee on Scientific Affairs. Dr Osborn also served on the Ad Hoc Committee on Child Abuse and Neglect and the SMS Committee on Women Physicians.

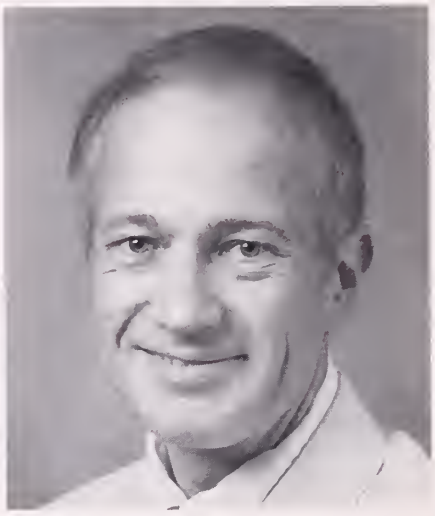
Michael C. Reineck, MD
West Bend
Vice speaker, House of Delegates
(1994-1996)
Dr Reineck graduated from the University of Wisconsin in 1970 and completed an internship at Milwaukee County General Hospital and a residency at St Mary's Hospital, in affiliation with the Medical School of the University of Michigan, in Grand Rapids. He has been in private practice at Orthopaedic Associates of West Bend, S.C., since 1975. Dr Reineck is chair of the Governmental Affairs Committee, and past president of the Wisconsin Orthopaedic Society and the Washington County Medical Society. He is also a member of the Wisconsin Professional Liability Committee, and the American Academy of Orthopaedic Surgeons ICD-9-CM Coding Committee, Health Care & Financing Committee, and Bylaws Committee. He has been the Washington County Medical Society delegate to the SMS House of Delegates for the past 10 years.

Richard H. Ulmer, MD
Marshfield
Chair, Board of Directors
Director, District 4
(1992-1995)
Dr Ulmer received his MD and MS in physiology from Stritch School of Medicine of Loyola University, Chicago. He served his internship and residency in cardiology at the University of Chicago Hospital and Clinics. He is a cardiologist at the Marshfield Clinic. Dr Ulmer was president of the Wood County Medical Society in 1978 and 1985. He has been chair of the SMS Board of Directors since 1989 and is a member of the SMS Steering Committee, AMA Forum of Employed Physicians, and SMS Committee for Young Physicians. He has been a member of the AMA Advisory Committee on Group Practice Physicians since 1992, and was an alternate delegate to the AMA for the past ten years. Dr. Ulmer will become a delegate to the AMA in calendar year 1995.

Raymond C. Zastrow, MD
Milwaukee
Vice chair, Board of Directors
Director, District 1
(1992-1995)
Dr Zastrow, who specializes in clinical pathology, graduated from Marquette University School of Medicine (now the Medical College of Wisconsin). He served on the SMS Physicians Alliance Commission from 1977 to 1989 and is a member of the WISPAC Board of Directors. He served as chair of the SMS bylaws committee, a member of the Finance Committee and was an alternate delegate to the AMA in 1983 to 1984. Dr Zastrow has also served on the SMS ad hoc committee on the Health Policy Agenda for the American People (HPA).

George R. Schneider, MD
West Allis
Director, District 1
(1994-1997)
A specialist in internal medicine, Dr Schneider graduated from Marquette University School of Medicine (now the Medical College of Wisconsin) in Milwaukee and served an internship at the University of Missouri Medical Center in Columbia. He also

Paul A. Wertsch, MD


John D. Wegenke, MD

Andrew B. Crummy, Jr, MD

Mark H. Andrew, MD

Jack M. Lockhart, MD

Robert J. Jaeger, MD

completed a residency at the Medical College. Dr Schneider is a member of the American Society of Internal Medicine and the American College of Physicians.

Robert F. Purtell, Jr, MD
Milwaukee
Director, District 1
(1992-1995)
Dr Purtell has been a member of the SMS Board of Directors and its Executive Committee since 1989. He was chair of the SMS Federal Legislative Policy Committee from 1977-1985, and a member of the Commission on Governmental Affairs from 1978-1985. He served as the delegate to the House of Delegates, Family Practice Section, and chair of the Physicians Alliance Commission from 1985 through 1989. Dr Purtell served on the Reference Committee on National Issues at the House of Delegates in 1980-1982. He was a member of the Nominating Committee from 1986-1994, serving as chair in 1989-1990. Dr Purtell has been active in the Wisconsin Academy of Family Physicians. He served as president of the Milwaukee County Medical Society in 1992-1993, and has been an alternate delegate to the AMA since 1990. He was president and chair of the board of directors of PrimeCare Health Plan of Wisconsin from 1982 through 1986. Dr Purtell graduated from Marquette University in 1961, and served his internship at Misericordia Hospital, in Milwaukee, and his residency at St Joseph's Hospital, in Milwaukee.

Thomas A. Reminga, MD
Milwaukee
Director, District 1
(1992-1995)
Dr Reminga, whose specialty is emergency medicine, graduated from the University of Michigan Medical School and completed his residency at the University of Chicago. He was a member of the SMS Health Planning Commission, is currently a delegate to the SMS and is currently a member of the Finance Committee and Holdings Board. He has served as president of the Wisconsin American College of Emergency Physicians and as president of the Medical Society of Milwaukee County. He is the director of Emergency Health Services of Milwaukee County.

Timothy G. McAvoy, MD
Waukesha
Director, District 1
(1993-1996)
Dr McAvoy graduated from New York Medical College. Specializing in internal medicine and emergency medicine, Dr McAvoy served his internship at Boston City Hospital. His residency was completed at Boston City Hospital and the University of Wisconsin Hospital and Clinics in Madison. He served as president of the Waukesha County Medical Society and has been a member of the Physicians Alliance Commission since 1987.

Marvin G. Parker, MD
Racine
Director, District 1
(1993-1996)
An hematologist, Dr Parker received his medical degree from the University of Missouri in St Louis, and served his residency and fellowship in internal medicine and hematology at the University of Missouri. Dr Parker began practice in Racine in 1966, and in 1986, joined SC Johnson Wax as corporate director of occupational and preventive medicine and in 1990 became vice president of Corporate Medical Affairs. He chaired the SMS Health Planning Commission for five years and also chaired the SMS Task Force on Medical Manpower.

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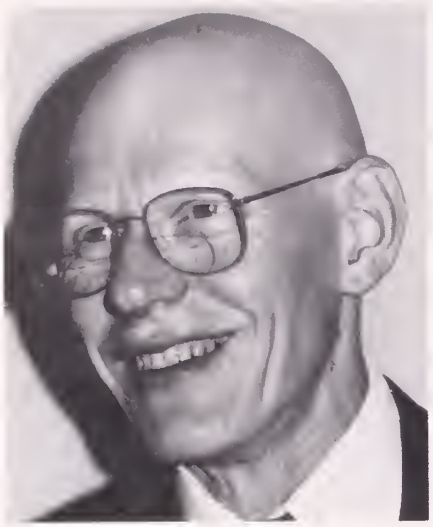

William E. Raduege, MD

James L. Basiliere, MD

Terry L. Hankey, MD

Continued from preceding page

Charles E. Pechous, Jr, MD
Kenosha
Director, District 1
(1993-1996)
Dr Pechous, a family practitioner and general surgeon, graduated from Loyola-Stritch School of Medicine. His internship and residency were completed at Cook County Hospital in Chicago. Currently, he is the medical director at the Modine Company in Racine. He is a member of the American College of Surgeons and the Wisconsin Chapter of the American College of Surgeons.

John E. Ridley, III, MD
Milwaukee
Director, District 1
(1993-1996)
Dr Ridley, an ophthalmologist, graduated from the University of Indiana School of Medicine. His residency was completed at the Marquette School of Medicine. He is currently the assistant clinical instructor in ophthalmology at the Medical College of Wisconsin. Dr Ridley served as a captain in the US Air Force from 1961 to 1963. He is a member of the Milwaukee Ophthalmology Society and the American Academy of Ophthalmology, vice-chairman of the Board of Directors Saint Mary's Hospital Milwaukee, vice-president of Prevent Blindness-Wisconsin, and a member of the Badger Association of the Blind advisory board.

Jay F. Schamberg, MD
Waukesha
Director, District 1
(1993-1996)
A pathologist, Dr Schamberg received his medical degree from Hahneman Medical College and served his internship at Chestnut Hill Hospital in Philadelphia. Dr Schamberg completed his residency at the Peter Bent Brigham Hospital in Boston and the University of Vermont Hospital in Burlington. He serves on the medical staffs of Community Memorial Hospital, West Allis Memorial Hospital, and Columbia Hospital. Dr Schamberg is past-president of the Wisconsin Society of Pathologists and a past president of Waukesha County Medical Society.

Frank H. Urban, MD
Brookfield
Director, District 1
(1994-1997)
Dr Urban is a retired physician and is currently the State Representative for the 99th Assembly District. He received his MD degree from the UW-Madison, and an MS from the University of Minnesota. Dr Urban is the president of the Milwaukee County Medical Society, an assistant clinical professor at the Medical College of Wisconsin, and is a member and past president of the Wisconsin Dermatology Society. Legislative appointments include the Assembly Committee on Health, Legislative Council Study Committee on Emergency Medical Services, and the Assembly Special Committee on Health Care Review.

Cyril M. (Kim) Hetsko, MD
Madison
Director, District 2
(1994-1997)
Dr Hetsko, a past president of the SMS, graduated from the University of Rochester School of Medicine and Dentistry and completed his internship and residency and was chief resident at the University of Wisconsin Hospitals. He has been a member of the Dean Medical Center since 1975 and is clinical professor of medicine at the University of Wisconsin, Madison. Dr Hetsko is active in the Wisconsin Society of Internal Medicine, serving as president from 1987 to 1988. He served as chair of the SMS Task Force on AIDS.

In addition, he was vice speaker of the SMS House of Delegates; a member of the Task Force on RBRVS, Strategic Planning Committee, and Task Force on Physician Discipline and Review; and served on the SMS Board of Directors for 9 years and was chair of its Finance Committee. He has been a member of the Wisconsin delegation to the AMA since 1983, serving as alternate delegate and is currently acting chair of the delegation. Dr Hetsko will become a delegate to the AMA in calendar year 1995. He is a past chair of the Department of Medicine at St Mary's Hospital Medical Center, Madison, and was a member of its Medical Staff Executive Committee. He is currently a member of the Infection Control and Pharmacy and Therapeutic committees, as well as a past member of its Institutional Review Board. He has received the Presidential Award from the Dane County Medical Society and the SMS Meritorious Service Award. Dr Hetsko is now a trustee of the American Society of Internal Medicine, and is a director of the Commission on Office Laboratory Accreditation.

Jerry M. Ingalls, MD
Monroe
Director, District 2
(1994-1997)
Dr Ingalls, is the medical director of The Monroe Clinic/Hospital and director of the Occupational Medicine department. He graduated from Duke University, Durham, North Carolina, completed his internship and residency at Duke University and the University of Oklahoma. A past president of the Illinois State Medical Society (1975), he presently serves on the SMS Commission on Health Care Financing and Delivery and is chairman of the SMS Task Force on Quality Assessment and Practice Parameters.

Ayaz M. Samadani, MD
Beaver Dam
Director, District 2
(1994-1997)
A family physician, Dr Samadani received his medical degree in Pakistan. He served his internship at Henrotin Hospitals in Chicago. He spent 5 years of post graduate training in internal medicine and pediatrics in London. He is a fellow of the Royal Society of Tropical Medicine and Hygiene and certified in child health from the Royal College of Physicians and Surgeons of London. He has been in practice in Beaver Dam since 1971, and is chair of the pediatric department of Beaver Dam Community Hospital. He has served as secretary and president of Dodge County Medical Society and is past-president of the Wisconsin chapter of the Association of Pakistani Physicians of North America. He is a fellow of the American Academy of Family Physicians.

Paul A. Wertsch, MD
Madison
Director, District 2
(1994-1997)
Dr Wertsch graduated from the University of Wisconsin Medical School in 1970. He completed a rotating internship at St. Paul Ramsey Hospital and a family practice residency at USPHS Indian Hospital in Gallup, N.M. He was a co-founder of the Wildwood Family Clinic, where he has been practicing since 1978. Dr Wertsch was chair of the Department of Family Practice, St. Mary's Hospital Medical Center from 1983-1986 and Chief of Staff at St. Mary's from 1988-1990. He chaired the Credentials Committee at St. Mary's from 1986-1988. He was president of the Dane County Medical Society in 1990-91. He was an alternate delegate to the SMS from 1986-1989 and a delegate from 1989 to the present. Committee experience includes credentials, pharmacy and therapeutics, utilization, bio-ethics, integrated quality assurance, bylaws,

Continued on next page

Stephen D. Hathway, MD

John E. Kraus, MD

David J. Deubler, MD

Lloyd R. Cotts, MD

Charles V. Ihle, MD

Robert L. Sellers, MD

Continued from preceding page
medical records, and executive.

John D. Wegenke, MD
Madison
Director, District 2
(1992-1995)
Dr Wegenke, a urologist, graduated from the University of Wisconsin Medical School in Madison. He served an internship at San Joaquin General Hospital in Stockton, Calif, and internships in general surgery and urology at University Hospital and Clinics in Madison. He is an editorial associate for the Wisconsin Medical Journal, and has served the Dane County Medical Society in various offices, including president.

Andrew B. Crummy, Jr, MD
Madison
Director, District 2
(1993-1996)
Dr Crummy is a professor of radiology at the University of Wisconsin Hospital and Clinics. A native of New Jersey, Dr Crummy graduated from Boston University Medical School and served his residency at University Hospital and Clinics in Madison. He has been a member of the editorial board for the *Wisconsin Medical Journal* from 1985 to 1994.

Mark H. Andrew, MD
Viroqua
Director, District 3
(1992-1995)
Dr Andrew, a general surgeon, graduated from the University of Wisconsin Medical School, and served his internship and residency at Southwestern Michigan Area Health Education Center in Kalamazoo. He was chairman of the Young Physicians Section of SMS in 1991. He also is a member of the SMS Physicians Alliance Commission, the SMS Ad Hoc Membership Committee, the SMS Nominating Committee and is the current president of the Vernon County Medical Society.

Jack M. Lockhart, MD
La Crosse
Director, District 3
(1992-1995)
A specialist in rheumatology, Dr Lockhart graduated from Harvard Medical School and served an internship at University Hospitals of Cleveland. He also completed fellowships at the University of Minnesota Medical School in Minneapolis. Dr Lockhart has served as a delegate to the SMS and as a member of the Nominating Committee. He also served on the SMS Physicians Alliance Commission for 9 years and is a member of the SMS Finance Committee and the Executive Committee of the La Crosse County Medical Society. He is also a past-president of the La Crosse County Medical Society.

Robert J. Jaeger, MD
Stevens Point
Director, District 4
(1994-1997)
Dr Jaeger is a specialist in obstetrics and gynecology. He attended the University of Wisconsin Medical School and served an internship and residency at Milwaukee County General Hospital. Dr Jaeger is an assistant clinical professor in the Department of Obstetrics and Gynecology at the Medical College of Wisconsin and serves on the board of directors of the University of Wisconsin Medical Alumni Association. He has served on the SMS Board of Directors since 1988 and is currently a member of the SMS Commission on Maternal and Child Health and the Maternal Mortality Committee. Dr Jaeger is a member of the board of directors for the Portage County Medical Society as well as an alternate delegate. He is president of the Wisconsin Society of OB/GYN and also chairman of the Wisconsin Section of the American College of Obstetrics and Gynecology.

William E. Raduege, MD
Woodruff
Director, District 4
(1992-1995)
William E. Raduege, MD has served as a board member since 1986. He has been board certified as a family practice physician since 1976 and has been practicing medicine in the Lakeland area of Minocqua-Woodruff since 1973. Dr Raduege is also a prior member of the Commission on Mediation and Peer Review from 1980-1989. Additionally, he is the current delegate to the State Medical Society from the Oneida-Vilas County Medical Society. Currently, Dr Raduege is an assistant clinical professor with the Medical College of Wisconsin and serves as a Preceptor with the University of Wisconsin Medical School.

James L. Basiliere, MD
Oshkosh
Director, District 5
(1992-1995)
Dr Basiliere was first elected to the Board of Directors in 1986. A board-certified specialist in internal medicine, Dr Basiliere graduated from the University of Wisconsin Medical School in Madison and served an internship and a residency at the San Diego Naval Hospital. He is a past president of the Winnebago County Medical Society, past president of the Fox Valley Academy of Medicine and past secretary of the Oshkosh Area Physicians Association. Dr Basiliere has been a member of the Board of Directors of the Wisconsin Medical Alumni Association since 1988.

Terry L. Hankey, MD
Waupaca
Director, District 5
(1993-1996)
Dr Hankey graduated from Wright State University and Duke University Medical College. He served his residency in family practice in Madison. He has been in practice in Waupaca for 18 years. For two years, he was residency director at the UW Family Practice Residency in Wausau. He is past president of the Wisconsin Academy of Family Physicians and an alternate delegate to the AAFP. He is a board member of the Wisconsin Institute of Family Medicine and a member of the AAFP Committee on Health Education. Dr Hankey was chairman of the WAFP Task Force on Access to Care.

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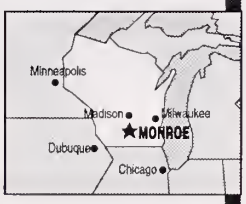

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WAUSAU MEDICAL CENTER
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Stephen D. Hathway, MD
Green Bay
Director, District 6
(1992-1995)
A pathologist, Dr Hathway graduated from the Indiana University School of Medicine in Indianapolis and completed an internship and residency at the South Bend Medical Foundation in South Bend, Ind. Dr Hathway is a member of the SMS Finance Committee. Dr Hathway was a member of the SMS Health Care Financing and Delivery Committee and served on the Committee on Alcoholism and Other Drug Abuse. He is also a past president and past secretary of the Brown County Medical Society.

John E. Kraus, MD
Marinette
Director, District 6
(1992-1995)
Dr Kraus has been a member of the Board of Directors since 1986. A specialist in internal medicine, he graduated from the University of Buffalo School of Medicine. He served an internship and residency in internal medicine at the Millard Fillmore Hospital in Buffalo and residencies in nephrology at Georgetown University Hospital and the Cleveland Clinic.

David J. Deubler, MD
Kiel
Director, District 6
(1994-1997)
Dr Deubler received his medical degree from the UW-Madison Medical School, and completed an internship and residency in family practice at UW Affiliated Hospitals-Wausau. A board certified family practitioner, he joined the Sheboygan Clinic in 1986 and presently practices in their satellite clinic in Kiel. He is a member of the American Academy of Family Practice and the Wisconsin Academy of Family Practice.

Lloyd R. Cotts, MD
Rice Lake
Director, District 7
(1992-1995)
Dr Cotts is a retired primary care physician. He graduated from the University of Wisconsin Medical School and served his internship at St. Joseph's Hospital, Marshfield. Dr Cotts served on the SMS Commission on Mediation and Peer Review and also served on the WIPRO Board. He is a past president of the Barron-Washburn-Burnett County Medical Society.

Charles V. Ihle, MD
Eau Claire
Director, District 7
(1994-1997)
Dr Ihle graduated from the UW-Madison Medical School in 1965. He interned at St. Mary's Hospital in San Francisco, and completed his residency in orthopedics at University Hospitals, Madison. He served in the US Navy from 1970-1973, as Chief of Orthopedics at the US Naval Hospital in Taipei, Taiwan. Dr Ihle has been practicing at the Ihle Orthopedic Clinic since July 1973. He is a member of the Commission on Health Care Financing and Delivery.

Robert L. Sellers, MD
Superior
Director, District 8
(1993-1996)
Dr Sellers graduated from the University of Illinois School of Medicine and is in family practice. He is a member of the SMS Finance and Executive committees. In addition, Dr Sellers is a past president of the Douglas County Medical Society.❖

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Timely, accurate information is essential in our complex, rapidly changing medical environment. Information—when you need it—on scientific issues, legislative issues, and socioeconomic issues is available from the SMS headquarters in Madison.

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A

Accounting ..... Jim Esselman
Accreditation (CME) ..... Kristin Krueger/ Lisa Lawry
Acquired Immune Deficiency Syndrome (AIDS) ..... Don Lord
Addictive Diseases, Commission on ..... Peter Alles/Karen Baier
Administrative rules ..... Colleen Wilson
Advance medical directives ..... Sally Wencel/ Colleen Wilson
Advertising, *Wisconsin Medical Journal* ..... Lynne Bjorgo
AIDS, Task Force on ..... Don Lord/Lisa Lawry
Alliance, SMS ..... Maria Van Cleve/Karen Butler
Allied health professionals ..... Sally Wencel
Alternative delivery systems ..... Sally Wencel/ Kevin Wymore
AMA Delegation ..... Tom Adams/ Margaret Wiersum
Americans with Disabilities Act ..... Sally Wencel
AMPAC ..... Mike Kirby
Annual meeting ..... Kristin Krueger
Antitrust ..... Mark Adams

B

Beaumont 500 Club ..... Julie Hein
Bequests ..... Julie Hein
Board of Directors ..... Tom Adams/ Margaret Wiersum
Bylaws: CMS, hospital medical staff ..... Sally Wencel

C

Candidate interviews ..... Field representatives
Capital expenditure review (CER) ..... Kathy Andersen
Capitol Update ..... Mike Kirby
Chiropractic ..... Colleen Wilson
Charitable, Educational & Scientific Foundation (CESF) ..... Julie Hein
Claim forms (HCFA) ..... Bill Guerten
Clinical Laboratory Improvement Act (CLIA Æ88) .... Sally Wencel/Tamara Larson
CME, accreditation ..... Kristin Krueger/ Lisa Lawry
Coding ..... Jan Rasmussen
Confidentiality ..... Sally Wencel/Sonia Porter
Commissions, appointments and reappointments ..... Don Lord
Communications ..... Russell King/ Shari Hamilton
Complaints about medical care ..... Sonia Porter/ Anne Bicha
Milwaukee office handling ..... Mary Thompson
Computers ..... Doug Turecek
Congress ..... Mike Kirby
Consent and related issues ..... Sally Wencel
Continuing Medical Education, Commission on ..... Kristin Krueger/ Lisa Lawry
Copy center and printshop ..... Dave Conner
Cost containment ..... Kevin Wymore
County medical society outreach ..... Field representatives

D

Data analysis ..... Peter Alles
Desktop publishing ..... Vicki Meyer
Domestic violence ..... Shari Hamilton/Lynn Sherman

E

Economic credentialing ..... Sally Wencel/ Anne Bicha
Elderly care ..... Lynn Sherman
Elderly drivers ..... Lynn Sherman
Emergency medical services (EMS) ..... Lynn Sherman
Endorsed programs ..... Noreen Krueger/ Lee Johnson
Environmental and Occupational Health Committee ..... Lynn Sherman/ Karen Baier
Ethical opinions ..... Sally Wencel
Ethics and medicine ..... Peter Alles
Executive Committee ..... Tom Adams/ Margaret Wiersum

F

Facilities manager ..... Don Temby
Farm safety ..... Lynn Sherman
Federal legislation ..... Mike Kirby
Federal Register review ..... All policy analysts
Fifty-Year Club ..... Lisa Lawry
Field representatives ..... Jim Hoegemeier
Cheryl McCollum
Maureen O'Brien
Steve Whittow
Finance Committee ..... Jim Esselman/
Sally Frankey
Fort Crawford-Museum of Medical
Progress ..... Julie Hein
Fraud and abuse—safe harbors, physician
self-referral ..... Sally Wencel/Anne Bicha
Friends of Academic Medicine
(FOAM) ..... Mike Kirby
Focus ..... Maria Van Cleve

G

Gambling addiction ..... Peter Alles
Geriatric Health, Commission on .....
Lynn Sherman/Merry Earll
Golf Classic (CESF) ..... Julie Hein
Governmental Affairs, Commission on .....
Mike Kirby/Judy Frey
Grant information ..... Jane Anderson
Group practice ..... Kevin Wymore
Group Practice Section ..... Don Lord
Gun violence and safety ..... Lynn Sherman

H

HCFA (claim) forms sales ..... Bill Guerten
Health care costs ..... Kevin Wymore
Health care data ..... Peter Alles/Sally Wencel
Health care economics ..... Kevin Wymore
Health Care Financing and Delivery,
Commission on ..... Kevin Wymore/
Merry Earll
Health Care Information,
Office of (OHCI) ..... Peter Alles
Health care rationing ..... Kevin Wymore
Health care reform ..... Colleen Wilson
Health care use ..... Policy analysts
Health insurance ..... Policy analysts
Health law ..... Mark Adams/Sally Wencel
Health maintenance organizations (HMOs) .....
Kevin Wymore/Anne Bicha
Health manpower ..... Anne Bicha
Health professional shortage areas
(HPSAs) ..... Anne Bicha
Hepatitis B vaccinations ..... Kevin Wymore
Home health care ..... Lynn Sherman
Hospice care ..... Lynn Sherman
Hospitals—regulation, accreditation .....
Sally Wencel
Hospital Medical Staff Section ..... Peter Alles
Hospital privileges ..... Sally Wencel
House of Delegates ..... Tom Adams
Human immunodeficiency virus (HIV) .....
Don Lord
Human resources ..... Barb Kopenski/
Bill Knollenberg

I

Impaired physicians ..... Sonia Porter/
John LaBissoniere
Individual practice associations
(IPAs) ..... Sally Wencel/Kevin Wymore
Individual rights—professional/practice
privacy ..... Sally Wencel
Information systems ..... Doug Turecek
Injury Prevention and Control,
Commission on ..... Lynn Sherman/
Karen Baier
Insurance law ..... Sally Wencel
Insurance, Office of the Commissioner of .....
Peter Alles
Insurance plans ..... see SMS Insurance Services
Integrated delivery services ..... Kevin Wymore
International Medical Graduates Section .....
Peter Alles
Interprofessional code ..... Mark Adams

J

Joint Commission on Accreditation
of Health Care Organizations ..... Sally Wencel/
Anne Bicha

K

Key contact system ..... Mike Kirby

L

Label requests and sales ..... Joyce Pease/
Jim Sartori
Lakedge Printing ..... Dave Conner
Lakeside Administrators, Inc. (LAI) .....
Jeanette Edwards/Joe Hinkes
Lakeside Association Services, Inc. (LASI) .....
Mike Eaton
Legal counsel ..... Mark Adams/Sally Wencel
Legislation ..... Mike Kirby
Kathy Andersen
Colleen Wilson
Legislative Directory ..... Karen Butler
Legislative issues booklet ..... Mike Kirby
Liability insurance regulations ..... Mark Adams/
Anne Bicha

Continued on next page

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Licensure ..... Sally Wencel/Colleen Wilson
Life endowment ..... Julie Hein
Living wills ..... Sally Wencel/Colleen Wilson
Lobbying ..... Mike Kirby
Kathy Andersen
Colleen Wilson

M

Mailroom ..... Dave Conner
Managed care ..... Mark Adams/
Kevin Wymore/Anne Bicha
Maternal and Child Health, Commission on .....
Kevin Wymore/Karen Baier
Media relations ..... Shari Hamilton/Russell King
Mediation and Peer Review, Commission on .....
Anne Bicha/Sonia Porter
Mediation panels ..... Mark Adams/Anne Bicha
Medicaid (Title 19) ..... Kevin Wymore
Medicaid and Medicare audits ..... Sally Wencel
Medicaid Medical Audit Committee .....
John LaBissoniere/Sonia Porter
Medical Assistance Technical Advisory
Committee ..... Kevin Wymore/Merry Earll
Medical Business Specialist
Certificate Program ..... Karen Garrett
Medical Examining Board
(MEB) ..... Colleen Wilson
Medical liability ..... Mark Adams/Anne Bicha
Medical Liability and Risk Management,
Commission on ..... Anne Bicha/Karen Baier
Medical outcomes research project .....
Sally Wencel/Peter Alles
Medical records ..... Sally Wencel/Sonia Porter
Medical residents ..... Anne Rittman
Medical service organizations ..... Kevin Wymore/
Sally Wencel
Medical Student Section ..... Anne Rittman
Medical Times ..... Shari Hamilton/Russell King
Medicare (Title 18) ..... Anne Bicha/Tamara Larson
Medicare coding ..... Tamara Larson
Medicine and Ethics, Commission on .....
Peter Alles/Merry Earll
Medigram ..... Shari Hamilton/Russell King
Meeting planning ..... Kristin Krueger
Membership ..... Anne Rittman
Joyce Pease
Michelle Kniess
Milwaukee office ..... Mary Thompson
Memorial giving program (CESF) ..... Julie Hein
Mini internship program ..... Field representatives
MinnesotaCare ..... Mark Adams
Museum, Fort Crawford Medical ..... Julie Hein

N

National Practitioner Data Bank .....
Sally Wencel/ Anne Bicha
Nominating Committee ..... Margaret Wiersum
Nursing homes ..... Lynn Sherman

O

Occupational health ..... Lynn Sherman
Occupational Safety and Health Act (OSHA)
Blood-borne Pathogen Standards .....
Lynn Sherman/Sally Wencel
Occupational Health Guide ..... Julie Hein
Office of Health Care Information (OHCI) .....
Peter Alles
Officers ..... Tom Adams
Optometry ..... Colleen Wilson
Organ transplants ..... Peter Alles
Outcomes management ..... Sally Wencel/
Peter Alles

P

PartnerCare ..... Tamara Larson
Patients Compensation Fund (PCF) .....
Mark Adams/Anne Bicha
Peer review ..... Anne Bicha/Sally Wencel
Peer Review Organization, Wisconsin
(WIPRO) ..... Anne Bicha/Sally Wencel
Pharmacy ..... Colleen Wilson
Physician Health Program, Statewide .....
John LaBissonaire/Sonia Porter
Physician hospital organization (PHO) .....
Mark Adams/Peter Alles
Physician income statistics ..... Mark Adams/
Anne Rittman
Physician manpower ..... Anne Bicha
Physician organizations (PO) ..... Mark Adams/
Peter Alles
Physician profiling ..... Sally Wencel
Physician support program ..... Anne Bicha/
Karen Baier
Physicians for Better Government
(PFBG) ..... Mike Kirby/Bruce Hesse
Physician's Guide to Wisconsin Health Law .....
Sally Wencel
Orders ..... Lynne Bjorgo
Physician statistics—general ..... Anne Rittman
Political action ..... Mike Kirby
Policy compendium ..... Maria Van Cleve
Pooled income fund ..... Julie Hein
Power of attorney for health care .....
Sally Wencel/Colleen Wilson
Practice management ..... Karen Garrett
Practice parameters ..... Peter Alles
Preferred provider organizations (PPOs) .....
Kevin Wymore

Primary Care Consortium ..... Lynn Sherman
Printshop and copy center ..... Dave Conner
Professional review organizations (PROs) ..... Sally Wencel
Public health ..... Policy analysts
Public Information, Commission on ..... Russell King/Lynne Bjorgo
Public relations ..... Russell King

Q

Quality Assessment/Practice Parameters, Task Force on ..... Sally Wencel
Quality Compliance, Bureau of ..... Lynn Sherman
Quality of care reviews ..... Anne Bicha

R

Regulation & Licensing, Department of (DRL) ..... Colleen Wilson
Resident Section ..... Anne Rittman
Resource Based Relative Value Scale (RBRVS) ..... Tamara Larson/Anne Bicha
Risk-adjusted data analysis ..... Peter Alles
Risk management ..... Mark Adams/Anne Bicha
Rural health ..... Anne Bicha/Mike Kirby

S

Safe transportation ..... Lynn Sherman
School health ..... Kevin Wymore
Scope of practice ..... Colleen Wilson/Sally Wencel
Scholarship program (CESF) ..... Jane Anderson
Scientific Medical Education Program ..... Kristin Krueger/Lisa Lawry
Seminars program ..... Karen Garrett
Senior Physicians, Wisconsin Association of ..... Julie Hein
Small Employer Insurance Board .. Colleen Wilson
SMS Holdings ..... Lee Johnson
SMS Insurance Services, Inc. ..... Mike Dolan
Speakers bureau ..... Steve Whittow
Specialty sections and societies .... Michelle Kniess
Speech writing (officers) ..... Russell King/Shari Hamilton

Continued on next page

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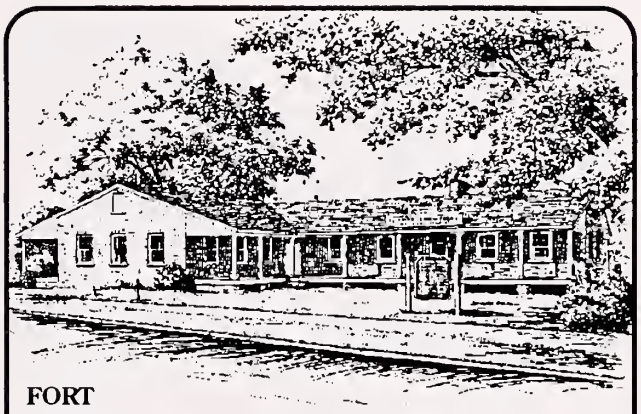

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Continued from preceding page

Strategic plan ..... Tom Adams
Student loan program (CESF) ..... Jane Anderson

T

Terminal care ..... Lynn Sherman
Third-party payors ..... Mark Adams/ Kevin Wymore
Tobacco and health ..... Lynn Sherman
Tobacco Free Wisconsin Coalition ..... Lynn Sherman/Kathy Anderson/Shari Hamilton
Tort reform ..... Mark Adams/Anne Bicha

U

Usual, customary and reasonable fees (UCR) ..... Anne Bicha/Kevin Wymore
Utilization review ..... Sally Wencel

W

WHCLIP/PCF Board of Governors ..... Mark Adams
WIPRO ..... Anne Bicha
Wisconsin Administrative Code .... Colleen Wilson
Wisconsin Medical Journal ..... Russell King/ Shari Hamilton
Wisconsin Medical Outcomes Research Network (WMORN) ..... Sally Wencel
Wisconsin Health Care Liability Insurance Plan (WHCLIP) ..... Mark Adams
WISPAC ..... Mike Kirby/Bruce Hesse
WNA-SMS Liaison, Commission on ..... Peter Alles/Karen Baier
Worker's Compensation ..... Mark Adams/ Mike Kirby/Lynn Sherman
Workshop on Health ..... Maria Van Cleve
WPS Medicare ..... Tamara Larson/Anne Bicha

Y

Young Physicians Section (YPS) ..... Anne Rittman

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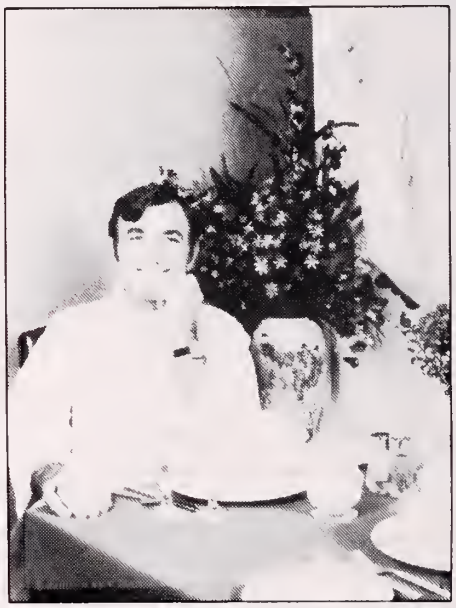

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SMS commissions and task forces: 1994-1995

THE FOLLOWING IS a list of SMS commissions and task forces, and their members for 1994-95. The original year of each member's appointment, as well as the expiration of his or her term, at the annual meeting of the year designated appears with each member's name. Chairs of commissions are appointed for 1-year terms by the Board of Directors. Vice chairs are elected at the first meeting of each commission following the annual meeting. This issue of the WMJ is prepared prior to most of these elections; therefore, some commissions will not include these designations.

Patricia Stuff, MD, casts her vote during the 1994 House of Delegates.

Commissions

Addictive Diseases
This commission shall be concerned with the prevention, treatment, and rehabilitation for persons affected by addictive disorders, with an emphasis on alcohol and other types of drug abuse.

Randall J. Kieser, MD, Madison, 1992/1992-1995, vice chair
George Locher, MD, Wausau, 1993/1993-1995
Thomas H. Peterson, MD, Wausau, 1989/1992-1995
Anne M. G. Schierl, MD, Stevens Point, 1989/1992-1995
Leonard W. Worman, MD, Milwaukee, 1993/1993-1995
Michael G. Deeken, MD, Wauwatosa, 1990/1993-1996
Fred H. Koenecke, Jr, MD, Madison, 1990/1993-1996, chair
Michael M. Miller, MD, Madison, 1990/1993-1996
Sheila W. Sorkin, MD, Sheboygan, 1993/1993-1996
Barbara L. Calhoun, MD, Madison, 1994/1994-1997
John R. Gladieux, MD, Milwaukee, 1988/1994-1997
David R. Hendricks, MD, Madison, 1994/1994-1997
Brian E. Lochen, MD, Madison, 1991/1994-1997
Edward O. Lukasek, MD, Sparta, 1986/1994-1997
Jeffrey Collins, medical student, UW
Jane Campbell, Neenah, Alliance
Irene Thearle, Neenah, Alliance

Staff support: Pete Alles/Karen Baier

Continuing Medical Education
This commission shall consist of up to 20 appointed members and the deans of the two medical schools in Wisconsin, or their designees, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, i.e., medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commission on Mediation and Peer Review and the Ad Hoc Committee on Health Planning for purposes of implementing continuing medical education programs related to responsibilities and activities of these two groups; and ongoing scientific programs of the State Medical Society. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continuing medical education within the state's medical schools.

Edward F. Banaszak, MD, Milwaukee, 1992/1992-1995
Vernon N. Dodson, MD, Madison, 1992/1992-1995
Warren J. Holtey, MD, Marshfield, 1990/1992-1995
Kesavan Kutty, MD, Milwaukee, 1993/1993-1995
L. Cass Terry, MD, Ph.D., Milwaukee, 1990/1992-1995
John W. Beasley, MD, Madison, 1988/1993-1996
Richard P. Day, MD, Madison, 1993/1993-1996
Paul R. Glunz, MD, Hubertus, 1993/1993-1996
James M. Lewis, MD, Baraboo, 1991/1993-1996
George Nemec, Jr, MD, Woodruff, 1987/1993-1996

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Continued from preceding page
Walter J. Vallejo, MD, La Crosse, 1988/1993-1996
Edward Zupanc, MD, Monroe, 1986/1993-1996
Harold G. Danford, MD, Appleton, 1991/1994-1997
Charles E. Fenlon, MD, Appleton, 1988/1994-1997
Thomas C. Gabert, MD, Woodruff, 1994/1994-1997
Thomas J. Grau, MD, La Crosse, 1991/1994-1997
Charles E. Holmburg, MD, Menomonee Falls, 1994/1994-1997
Elizabeth T. Sanfelippo, MD, Fond du Lac, 1990/1994-1997
Dianne L. Zwicke, MD, Milwaukee, 1987/1994-1997, chair

Medical School Deans' designees:
Thomas C. Meyer, MD, UW-Madison
Timothy J. Van Susteren, Ph.D., Medical College of Wisconsin

Staff support: Kristin Krueger/Lisa Lawry

Environmental and Occupational Health
This commission shall be concerned with the health and safety of persons in relation to their environment and occupation.

Henry A. Anderson, MD, Madison, 1992/1992-1995
James L. Basiliere, MD, Oshkosh, 1989/1992-1995
Jane K. Sliwinski, MD, Green Bay, 1990/1992-1995
Sridhar V. Vasudevan, MD, Brookfield, 1989/1992-1995
Carl Zenz, MD, West Allis, 1986/1992-1995
Tuenis D. Zondag, MD, Eau Claire, 1994/1994-1995
John T. Bolger, MD, Waukesha, 1990/1993-1996
Larry A. Lindesmith, MD, La Crosse, 1993/1993-1996
Donald B. Lindorfer, MD, Waukesha, 1993/1993-1996
Thomas T. Midthun, MD, Baraboo, 1993/1993-1996
J. Steven Moore, MD, Milwaukee, 1985/1993-1996
Marvin G. Parker, MD, Racine, 1994/1994-1996
David L. Drury, MD, Racine, 1994/1994-1997
Michael J. Goldstein, MD, Madison, 1994/1994-1997
Julie N. Larsen, MD, Oconomowoc, 1992/1994-1997, vice chair
Mark C. Moore, MD, Madison, 1994/1994-1997
John J. Ouellette, MD, Madison, 1991/1994-1997
Mark A. Roberts, MD, Milwaukee, 1991/1994-1997, chair
Susan M. Abell, Kenosha, WMGMA representative
Gwen McIntosh, medical student, UW
Betty Kuplic, Sheboygan, Alliance

Staff support: Lynn Sherman/Karen Baier

Geriatric Health
This commission shall be concerned with geriatric health care issues and services, the process of aging, and the means to achieve the best possible health status and care for the aged. This shall include services provided in nursing facilities and in the home.

Joseph N. Blustein, MD, Madison, 1992/1992-1995, vice chair
Bruce A. Kraus, MD, Columbus, 1990/1992-1995
Gary J. Leo, DO, Milwaukee, 1993/1993-1995
Michael G. O'Mara, MD, Oconomowoc, 1994/1994-1995
George Mathai, MD, Elm Grove, 1994/1994-1996
Edwin G. May, MD, Stevens Point, 1993/1993-1996
Mark A. Sager, MD, Madison, 1990/1993-1996
Thomas H. Williams, MD, Mukwonago, 1987/1993-1996
Richard S. Kane, MD, Milwaukee, 1989/1994-1997, chair
Edward O. Lukasek, MD, Sparta, 1988/1994-1997
Thomas M. Naughton, MD, New Berlin, 1994/1994-1997
Scott S. Erickson, MD, Marshfield, 1994/1994-1997
Sarah de Grood, medical student, UW
Sandra Kontra, Racine, Alliance

Staff support: Lynn Sherman/Merry Earll

Governmental Affairs
This commission shall plan, organize, and implement programs to protect and preserve the legislative, socioeconomic, and political interests of the members of the State Medical Society of Wisconsin. The commission shall analyze state and federal legislation and administrative rules and policies, and recommend to the Board of Directors specific actions and positions designed to carry out this responsibility. The commission shall also inform the membership of the Society regarding proposed legislation and other public policy initiatives, seek the enactment of legislation for the best interests of the public, scientific medicine, and the medical profession, and promote and encourage Society members to be politically active individually and collectively. This commission shall act to protect the socioeconomic interests of the Society membership in public and private health care delivery systems and recommend to the Board of Directors specific strategies and efforts to achieve this purpose. This commission shall consist of members appointed by the Board of Directors in a number deemed sufficient to execute the responsibilities delegated to the commission. Membership on the commission shall also include a repre-

sentative from each of the specialty sections of the Society, subject to approval by the Board of Directors. These representatives shall be appointed by the sections annually, and shall have the right to vote on all matters before the commission. The President, President-elect, Immediate Past President, and Chairman of the Board of the Society shall serve as ex officio members of the commission with vote.

Gary L. Bryant, MD, La Crosse, 1993/1993-1995
Carl S. Eisenberg, MD, Milwaukee, 1984/1992-1995, chair
Raymond R. Johnson, MD, Wauwatosa, 1993/1993-1995
Michael J. Kryda, MD, Marshfield, 1989/1992-1995
Larry M. Ojeda, MD, Beloit, 1989/1992-1995
Michael P. Mehr, MD, Marshfield, 1985/1992-1995
Bernard F. Micke, MD, Madison, 1986/1992-1995
Joseph E. Trader, MD, Manitowoc, 1989/1992-1995
Mark H. Andrew, MD, Viroqua, 1990/1993-1996
Steven K. Dankle, MD, Milwaukee, 1990/1993-1996
Vernon N. Dodson, MD, Madison, 1985/1993-1996
James W. Hoftiezer, MD, Two Rivers, 1993/1993-1996
Ronald R. Martins, MD, Elm Grove, 1994/1994-1996
Timothy G. McAvoy, MD, Waukesha, 1987/1993-1996
Robert M. Stern, MD, Milwaukee, 1990/1993-1996
DeLore Williams, MD, Elm Grove, 1985/1993-1996
Gregory B. Buck, MD, Wauwatosa, 1990/1994-1997
James Embrescia, MD, Madison, 1994/1994-1997
Bruce A. Kraus, MD, Columbus, 1988/1994-1997
John F. Pope, MD, Wauwatosa, 1994/1994-1997
Patrick L. Remington, MD, Madison, 1993/1994-1997
Thomas Slota, MD, Milwaukee, 1992/1994-1997
Sridhar V. Vasudevan, MD, Brookfield, 1994/1994-1997
Sheldon A. Wasserman, MD, Milwaukee, 1992/1994-1997
Alice Soule, Madison, WMGMA representative
Jeri Cushman, Racine, Alliance

President: Richard G. Roberts, MD, Madison
President-elect: Marcia J.S. Richards, MD, Milwaukee
Immediate Past President: Pauline M. Jackson, MD, La Crosse
Chair of the Board: Richard H. Ulmer, MD, Marshfield

Section representatives
Allergy Section: Donald A. Bukstein, MD, Madison
Anesthesiology Section: John F. Kreul, MD, Madison
Cardiology Section: Michael P. Cinquegrani, MD, Milwaukee
Dermatology Section: Eric R. Berg, MD, Madison
Emergency Medicine Section: Thomas J. Luetzow, MD, Larsen
Family Physicians Section: Calvin S. Bruce, MD, Madison
Internal Medicine Section: Susan L. Turney, MD, Marshfield
Neurology Section: Gamber F. Tegtmeyer, Jr, MD, Madison
Neurosurgery Section: Mohammed Rafiullah, MD, Racine
Obstetrics-Gynecology Section: Robert K. DeMott, MD, Green Bay
Ophthalmology Section: Jack L. Hughes, MD, Wauwatosa
Orthopaedic Section: Robert O. Buss, MD, Brookfield
Otolaryngology Section: Ashley G. Anderson, Jr, MD, Madison
Pathology Section: Roland C. Brown, MD, West Bend
Pediatrics Section: Kathryn P. Nichol, MD, Milwaukee
Physical Medicine and Rehabilitation Section: Keith B. Sperling, MD, Madison
Plastic Surgery: Benjamin A. VanRaalte, MD, Waukesha
Preventive Medicine: Jane K. Sliwinski, MD, Green Bay

Continued on next page

Rep Tom Barrett addresses the SMS House.

Continued from preceding page
Psychiatry: Robert F. Goerke, MD, Milwaukee
Radiation Oncology Section: Howard J. Lewis, MD, Milwaukee
Radiology: Timothy T. Flaherty, MD, Neenah
Surgery Section: James A. Avery, MD, Fond du Lac
Rob Nandalur, medical student, UW

(Other Section Representatives to be appointed)

Staff support: Mike Kirby/Judy Frey

Health Care Financing and Delivery
This commission shall be concerned with all aspects of health care financing and delivery systems, including managed health care plans, and shall promote an ongoing dialogue on these issues with business, industry, labor and, when appropriate, government agencies. It shall also be concerned with access and financing issues for rural and inner city health.

Paul G. Harkins, MD, Marshfield, 1990/1992-1995
Peter R. Holzhauer, MD, Brookfield, 1993/1993-1995
Jerry M. Ingalls, MD, Monroe, 1989/1992-1995
Kermit L. Newcomer, MD, La Crosse, 1987/1992-1995, chair
Harry Prosen, MD, Milwaukee, 1994/1994-1995, vice-chair
William C. Rupp, MD, Eau Claire, 1993/1993-1995
Warren H. Williamson, MD, Racine, 1984/1992-1995
Edward J. Coleman, MD, Green Bay, 1992/1993-1996
Daniel D. Gilman, DO, Milwaukee, 1993/1993-1996
Frank S. Guzowski, MD, Marshfield, 1993/1993-1996
Kenneth O. Johnson, MD, Milwaukee, 1993/1993-1996
Craig Larson, MD, Milwaukee, 1993/1993-1996
Rudolf W. Link, MD, Lodi, 1990/1993-1996
Angelina M. Montemurro, MD, Kenosha, 1993/1993-1996
John R. Petersen, MD, Wauwatosa, 1994/1994-1996
Clyde M. Chumbley, II, MD, Menomonee Falls, 1991/1994-1997
Julian E. De Lia, MD, Milwaukee, 1994/1994-1997
Charles V. Ihle, MD, Eau Claire, 1992/1994-1997
John E. Midtling, MD, Milwaukee, 1994/1994-1997
Kenneth I. Robbins, MD, Madison, 1994/1994-1997
Norman J. Schroeder, II, MD, Green Bay, 1989/1994-1997
Sidney Shindell, MD, Milwaukee, 1994/1994-1997
Gregory A. Shove, MD, Racine, 1994/1994-1997
Frank H. Urban, MD, Brookfield, 1993/1994-1997
Joan Albian, Milwaukee, WMGMA representative
Erik Gundersen, medical student, UW
Stephanie Wojtowicz, medical student, UW

Staff support: Kevin Wymore/Merry Earll

Medical Assistance Technical Advisory Committee (work group)
The SMS created this advisory group to work with the Bureau of Health Care Financing on issues of mutual concern regarding the Medicaid program. Issues for the group's consideration include: MA reimbursement, claims issues and the performance of EDS, copayments, MA/HMO's, prior authorizations and other regulatory requirements. This advisory group is a subcommitte of the Commission on Health Care Financing and Delivery, and any recommendations made by the subcommittee will be referred to the parent commission for review and approval.

Daniel D. Gilman, DO, Milwaukee, chair
Marc F. Hansen, MD, Madison
Russell F. Lewis, MD, Madison
Nancy Ness, MD, Mauston
Wayman Parker, MD, Milwaukee
Guenther P. Pohlmann, MD, Milwaukee, vice chair
Warren H. Williamson, MD, Racine
Arlene L. Lueck, Madison, WMGMA representative
Kevin Piper, Madison, DHSS
Alison Pritchit, medical student, UW

Staff support: Kevin Wymore/Merry Earll

Injury Prevention and Control
This commission shall be concerned with the health and safety of all who may be affected by the use of vehicles of transportation on land or water, or in the air. This includes the responsibility to review the emergency medical systems in Wisconsin that serve the needs of those injured in transportation accidents.

Robert W. Jones, MD, Racine, 1994/1994-1995
Richard D. Lindgren, MD, Madison, 1986/1992-1995
Thomas J. Luetzow, MD, Watertown, 1986/1992-1995, chair
Richard L. Ellis, MD, Middleton, 1994/1994-1995
William H. Perloff, MD, Madison, 1992/1992-1995
James L. Concannon, MD, Kenosha, 1993/1993-1996
Kevin J. Fullin, MD, Kenosha, 1994/1994-1996, vice chair
Phiroze L. Hansotia, MD, Marshfield, 1992/1993-1996
Ralph F. Hudson, MD, Eau Claire, 1989/1993-1996

Frederick W. Blancke, MD, Madison, 1994/1994-1997
Larry E. La Crosse, MD, Mequon, 1994/1994-1997
Bernard F. Micke, MD, Madison, 1994/1994-1997
Judith D. Pruski, MD, Fond du Lac, 1994/1994-1997
Joanne A. Selkurt, MD, Whitehall, 1994/1994-1997
Maxine Omdahl, Racine, Alliance

Staff support: Lynn Sherman/Karen Baier

Maternal and Child Health
This commission shall be concerned with all aspects of health in pregnancy, childbirth and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

Jerome H. Gundersen, MD, La Crosse, 1989/1992-1995
Robert J. Miller, MD, Hales Corners, 1992/1992-1995
Paul R. Myers, MD, Neenah, 1992/1992-1995
Ordean L. Torstenson, MD, Madison, 1989/1992-1995
Patricia A. Barwig, MD, Milwaukee, 1990/1993-1996
Susan C. Fee, MD, Marshfield, 1991/1993-1996, chair
Jean Ricci Goodman, MD, Marshfield, 1993/1993-1996
Robert J. Jaeger, MD, Stevens Point, 1994/1994-1996
Cynthia L. Jones-Nosacek, MD, Milwaukee, 1993/1993-1996
Timothy J. O'Neil, MD, Columbus, 1991/1993-1996
John E. Inman, MD, Monroe, 1991/1994-1997
Murray L. Katcher, MD, PhD, Madison, 1988/1994-1997
John D. Kenny, MD, Madison, 1987/1994-1997
Jeffrey H. Lamont, MD, Wausau, 1994/1994-1997
James A. Meyer, MD, Marshfield, 1988/1994-1997, vice chair
Rayna Truedeau, medical student, MCW

Staff support: Kevin Wymore/Karen Baier

Study Committee on Maternal Mortality Survey
Gloria M. Halverson, MD, Waukesha, chair
Perry A. Henderson, MD, Madison
John E. Inman, MD, Monroe
Robert J. Jaeger, MD, Stevens Point
Stanley A. Korducki, MD, Milwaukee
Paul R. Meier, MD, Marshfield
Bernard B. Poeschel, MD, Eau Claire
Herbert F. Sandmire, MD, Green Bay
Walter R. Schwartz, MD, Wauwatosa
Dorothy V. Skye, MD, Rhinelander
Steven D. Stenzel, MD, Menomonie
E. Howard Theis, MD, Fond du Lac
Dennis Worthington, MD, Milwaukee

Staff support: Kevin Wymore/Merry Earll

Mediation and Peer Review
This commission shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, on matters relating to quality of care, and professional ethics. When necessary, it shall initiate disciplinary or other action as appropriate. It shall serve as the Society's advisory body to private or governmental organizations on matters affecting medical peer review including utilization review, appropriateness of care, and quality assurance. It shall advise and consult with component societies on issues of peer review, mediation, ethics, and discipline in concert with members of the Board of Directors. It shall serve as the initial appellate body for peer review and mediation issues that are appealed from local committees of component societies. It shall coordinate the Statewide Physician Health Program.

Continued on next page

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Continued from preceding page
Frederick W. Blancke, MD, Madison, 1987/1992-1995
James E. Gutenberger, MD, Madison, 1986/1992-1995
Kenneth O. Johnson, MD, Milwaukee, 1992/1992-1995
Lyle L. Olson, MD, Darlington, 1985/1992-1995
Richard D. Sautter, MD, Marshfield, 1992/1992-1995
Donald F. Weber, MD, Eau Claire, 1992/1992-1995
John B. Weeth, MD, La Crosse, 1992/1992-1995
Philip J. Dougherty, MD, Menomonee Falls, 1987/1993-1996
Charles S. Geiger, Jr, MD, West Bend, 1993/1993-1996
Michael H. Gilman, DO, Milwaukee, 1994/1994-1996
Martin L. Lobel, MD, Milwaukee, 1993/1993-1996
Michael J. O'Neill, MD, Green Bay, 1987/1993-1996
David A. Satchell, MD, Manitowoc, 1990/1993-1996
Santiago L. Yllas, MD, Racine, 1987/1993-1996
Bruce B. Berry, MD, Milwaukee, 1991/1994-1997, chair
Fernando B. Bersalona, MD, Marshfield, 1994/1994-1997
Lucille B. Glicklich, MD, Milwaukee, 1994/1994-1997
Donald R. Gore, MD, Sheboygan, 1992/1994-1997
James P. Long, MD, Beloit, 1987/1994-1997
George A. Pagels, MD, Marshfield, 1988/1994-1997
William A. Wood, MD, Madison, 1994/1994-1997
John E. Woodford, MD, Madison, 1992/1994-1997
Virgil L. Sharp, DO, Waterloo, representing the Wisconsin Association of Osteopathic Physicians and Surgeons

Staff support: Anne Bicha/Sonia Porter

Coordinating Council on Physician Impairment
Gerald C. Kempthorne, MD, Spring Green (SMS)
Fred H. Koenecke, Jr, MD, Madison (SMS)
Michael M. Miller, MD, Madison (SMS)
Mikki Patterson, Madison, public member (MEB)
Clark O. Olsen, MD, Ashland (MEB)
Walter R. Schwartz, MD, Wauwatosa (MEB)

Staff support: John LaBissoniere/Sonia Porter

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Marcia J. S. Richards, MD, Milwaukee

Medical Director, SPHP
David G. Benzer, DO, Wauwatosa

Staff support: John LaBissoniere/Sonia Porter

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D. Mark Lochner, MD, Waupaca
Virgil L. Sharp, DO, Waterloo, representing the Wisconsin Association of Osteopathic Physicians and Surgeons
G. John Weir, Jr, MD, Marshfield

Staff support: John LaBissoniere/Sonia Porter

Medical Liability and Risk Management
This commission shall monitor current risk management developments and examine the range of options to reduce liability exposure.

Gregory B. Buck, MD, Wauwatosa, 1993/1993-1995
Joseph C. DiRaimondo, MD, Manitowoc, 1990/1992-1995
Sidney E. Johnson, MD, Marshfield, 1987/1992-1995, chair
John J. Kelly, MD, Wauwatosa, 1993/1993-1995
Steven L. Lawrence, MD, Milwaukee, 1989/1992-1995
Daniel W. Shea, MD, DePere, 1993/1993-1995
W. Scott Carpenter, MD, Marshfield, 1993/1993-1996
Jerome W. Fons, Jr, MD, Greenfield, 1989/1993-1996
Kenneth M. Klatt, MD, Madison, 1993/1993-1996
Charles Schauberger, MD, La Crosse, 1993/1993-1996
Carolyn Ogland Vukich, MD, Madison, 1991/1993-1996
S. Marshall Cushman, Jr, MD, Racine, 1988/1994-1997
Donald L. Feinsilver, MD, West Allis, 1994/1994-1997
Thomas M. Kidder, MD, Milwaukee, 1987/1994-1997, vice chair
Abraham Varghese, MD, Milwaukee, 1994/1994-1997

Michael A. Weiner, MD, Madison, 1994/1994-1997
Laurens D. Young, MD, Milwaukee, 1993/1994-1997
Alice Soule, Madison, WMGMA representative
John Tomashek, medical student, UW
Fe Abellera, Onalaska, Alliance

Staff support: Anne Bicha/Karen Baier

Medicine and Ethics
This commission shall be concerned with the ethical aspects of medical practice in order to permit discussion of common problems in the total treatment and care of patients; and, to clarify the relationship between ethics and science in medicine.

Donald R. Beaver, DO, Milwaukee, 1992/1992-1995
Steven H. Cohen, MD, Milwaukee, 1993/1993-1995
Wm. Michael Cross, MD, Green Bay, 1992/1992-1995
David J. Matteucci, MD, Kenosha, 1989/1992-1995
Armond H. Start, MD, Madison, 1993/1993-1995
Richard J. Thurrell, MD, Madison, 1990/1992-1995
Richard A. Dart, MD, Marshfield, 1993/1993-1996
Charles E. Gessert, MD, Milwaukee, 1993/1993-1996
Charles L. Junkerman, MD, Milwaukee, 1990/1993-1996
J D Kabler, MD, Madison, 1990/1993-1996, chair
Kathryn P. Nichol, MD, Milwaukee, 1993/1993-1996, vice chair
Philip J. Dougherty, MD, Menomonee Falls, 1991/1994-1997
Russell F. Lewis, MD, Madison, 1994/1994-1997
William J. Listwan, MD, West Bend, 1994/1994-1997
John K. Scott, MD, Madison, 1990/1994-1997
Rodney W. Sorensen, DO, Marshfield, 1987/1994-1997
William G. Weber, MD, Oshkosh, 1991/1994-1997
Anne Jacobson, medical student, UW
Erik Schoff, medical student, UW
Leah Speltz, Wausau, Alliance

Staff support: Pete Alles/Merry Earll

Public Information
This commission shall be concerned with the members of this Society and their image with the public. It shall plan and execute programs of effective public information and health education, assist component societies in the conduct of similar programs, develop effective media relations.

Khosro Adib, MD, Madison, 1994/1994-1995
Michelle L. Bachhuber, MD, Marshfield, 1993/1993-1995

The color guard proudly opens the 1994 SMS House of Delegates.

David R. Del Toro, MD, Greenfield, 1992/1992-1995
Edward G. Kass, MD, Waukesha, 1994/1994-1995
Jane M. Collis-Geers, MD, Milwaukee, 1993/1993-1996
Robert E. Phillips, MD, Marshfield, 1993/1993-1996
Gary C. Steven, MD, Milwaukee, 1993/1993-1996
Jeffry J. Young, DO, Green Bay, 1993/1993-1996
Clarence P. Chou, MD, Mequon, 1991/1994-1997
S. Roger Hirsch, MD, Milwaukee, 1994/1994-1997
Bradley L. Manning, MD, Madison, 1991/1994-1997
Benjamin C. Wedro, MD, La Crosse, 1987/1994-1997, chair
Roberta Baldwin, Watertown, Alliance

Staff support: Russell King/Lynne Bjorgo

Wisconsin Medical Journal
The *Wisconsin Medical Journal* shall be the official journal of the Society. An editorial board consisting of the medical editor as chair and no less than six additional members shall be responsible for all scientific, editorial, and business affairs of the *Journal*. An editorial director, serving as chair of a group of no less than five editorial associates, shall be responsible for regularly providing items of editorial opinion for publication in the editorial pages of the *Journal*.

Richard D. Sautter, MD, Marshfield, 1990/1994-1995, chair and medical editor
Charles C. Canver, MD, Madison, 1994/1994-1995
J D Kabler, MD, Madison, 1989/1992-1995
Jeffrey H. Lamont, MD, Wausau, 1989/1992-1995
Susan F. Behrens, MD, Beloit, 1991/1993-1996
Martin D. Hoffman, MD, Milwaukee, 1994/1994-1996
Kesavan Kutty, MD, Milwaukee, 1994/1994-1996
Donald S. Schuster, MD, Madison, 1991/1994-1997
Benjamin C. Wedro, MD, La Crosse, 1993/1994-1997

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Continued from preceding page
Victor S. Falk, MD, Edgerton, medical editor emeritus

Staff support: Russell King/Lynne Bjorgo

WNA-SMS Liaison
This commission shall be concerned with developing recommendations, as appropriate, regarding education, legislation, practice arrangements and delivery patterns; shall facilitate understanding and acceptance by the professions and the public of changing medical and nursing relationships, roles and practices; shall serve as a consultation resource in matters that relate to joint practice.

SMS members:
Robert T. Cooney, MD, Portage, 1987/1992-1995
Marc F. Hansen, MD, Madison, 1987/1992-1995
Sandra L. Osborn, MD, Madison, 1990/1993-1996, co-chair
Charles E. Pechous, Jr, MD, Kenosha, 1993/1993-1996
Charles E. Gessert, MD, Milwaukee, 1994/1994-1997

WNA members:
Barbara Friedbacher, RN, Brookfield
Vickie Gukenberger, RN, Wisconsin Rapids, co-chair
Barbara Nichols, RN, Madison
Ronnie Peterson, RN, Evansville
Leona VandeVusse, RN, Milwaukee

Staff support: Pete Alles/Karen Baier

Task forces

Task Force on AIDS
In 1987 the Board of Directors established this task force to advise members of the State Medical Society on the formulation of public policy to address the scientific, medical, ethical, legal, and legislative issues pertaining to AIDS.

SMS members:
Patricia M. Barwig, MD, Milwaukee
Gerald J. Dorff, MD, Milwaukee
John F. Doyle, DDS, Madison
Charles E. Gessert, MD, Milwaukee
Ian H. Gilson, MD, Milwaukee
Jerome H. Gundersen, MD, La Crosse
Cyril M. Hetsko, MD, Madison, chair
Stanley L. Inhorn, MD, Madison
Charles L. Junkerman, MD, Milwaukee
J. Douglas Lee, MD, Marshfield
Richard M. Reich, MD, Madison
Thomas L. Schlenker, MD, Milwaukee
Jeffrey E. Taxman, MD, Milwaukee
Louise Scott, Madison, Alliance

WHA member:
Jane Olson, WHA, Madison
Special advisory members:
Jeffrey P. Davis, MD, Madison
James M. Vergeront, MD, Madison

Staff support: Don Lord/Lisa Lawry

Task Force on Quality Assessment and Implementation of Practice Parameters
To ensure that Wisconsin physicians assume a knowledgeable role in the continuing discussion of quality medical care, the task force shall review and monitor developments within each of the following areas: practice parameters; severity measurement systems, methods for continuous quality improvement and other systems for quality assessment and enhancement; and Wisconsin specific projects including the State Office of Health Care Information and the state pilots in the Health Care Financing Information and the state pilots in the Health Care Financing Administration's Ambulatory Review Project and Uniform Clinical Data Set Project. Further, the task force shall develop a plan for the future role of the Society in the assessment of quality and the implementation of practice parameters.

Fredrik F. Broekhuizen, MD, Whitefish Bay
Thomas H. Browning, MD, Madison
Philip J. Dahlberg, MD, La Crosse
Kevin T. Flaherty, MD, Wausau
Norman W. Hoover, MD, Milwaukee
Jerry M. Ingalls, MD, Monroe, chair
Nicholas E. Mischler, MD, Madison
George A. Pagels, MD, Marshfield
Thomas A. Reminga, MD, Milwaukee
Ayaz M. Samadani, MD, Beaver Dam
Peter A. Sanderson, MD, Plover
John O. Simenstad, MD, Osceola
Russell S. Yale, MD, Mequon
Bruce Kruger, Madison, WMGMA representative

Staff support: Sally Wencel/Merry Earll

Medical Schools/SMS Relations Committee
To reach areas of commonality and understanding and to develop an agenda to determine what should comprise the practice of medicine in the year 2000.

The effort to coordinate medical school activities with the profession warranted this commitment to listen and educate its leadership on problems facing the colleges.

SMS members
Ashley G. Anderson, Jr., MD, Madison
Patricia A. Barwig, MD, Milwaukee
Clyde M. Chumbley, II, MD, Menomonee Falls
James L. Concannon, MD, Kenosha
J. Timothy Harrington, Jr., MD, Madison
Richard A. Leer, MD, Marshfield
Albert J. Motzel, Jr., MD, Waukesha
K. Kwang Soo, MD, Milwaukee
Robert S. Witte, MD, La Crosse

MCW members
Edmund H. Duthie, MD, Milwaukee
Stanley Kaplan, PhD, Milwaukee
Janet C. Lindemann, MD, Milwaukee
David Schiedermayer, MD, Milwaukee
Alonzo Walker, MD, Milwaukee

UW members
Paul P. Carbone, MD, Madison
Theodore Goodfriend, MD, Madison
Richard Helgerson, MD, Madison
Elaine Mischler, MD, Madison
Susan Skochelak, MD, Madison

Staff support: Kristin Krueger/Lisa Lawry

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Key: president (P), president elect (PE), vice president (VP), secretary (S), treasurer (T), secretary-treasurer (ST), executive secretary (ES), executive vice president (EVP), executive director (ED). As of July 1, 1994.

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ST--Robert B Pierpont, MD
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715-822-2231
S—John A Cragg, MD
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Rice Lake 54868
715-234-9031
T—Donald E Riemer, MD
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Green Bay 54307-3508
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Green Bay 54301-1439
414-499-8859

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P—Ricarte E Lozada, MD
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Chilton 53014
414-849-2386
VP—Badri N Ganju, MD
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Chilton 53014
414-849-2888
ST—William E Hannon, MD
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414-849-2386

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21083 E Ridgeway Drive
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ST—Jerry Gehl, MD
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ES—James Splitek
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Continued on next page

Kevin Flaherty, MD, (l) receives a Beaumont 500 Award, on behalf of the Marathon County Medical Society, from Dr Stephen Webster (r) at the 1994 annual meeting.

Continued from preceding page

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Dr Perry Henderson (r) receives a Meritorious Service Award from then-SMS President Pauline Jackson, MD, (l) at the 1994 annual meeting.

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Continued on next page

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Key: chair (C), chair elect (CE), vice chair (VC), secretary (S), treasurer (T), secretary-treasurer (ST), delegate (D), alternate delegate (AD), AMA delegate (AMAD), AMA alternate delegate (AMA AD). As of July 1, 1994.

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Continued on next page

William Listwan, MD, (l) shares his wit with Shari Hamilton, WMJ assistant editor, (r) at the 1994 WISPAC reception.

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Harry Zemel, MD, delivers the 1994 treasurer's report.

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715-358-1235
ST--Eberhard A Mack, MD
G5/358 UW CSC
600 Highland Ave
Madison 53792
608-263-1387

Wisconsin Chapter: American College of Surgeons
P—James H Woods, MD
2300 N Mayfair Rd #845
Wauwatosa 53226
414-453-2121
PE--Ronald D Wenger, MD
1912 Atwood Ave
Madison 53704
608-241-4611
VP—William D Turnipseed, MD
H4/330 UW CSC
600 Highland Ave
Madison 53792
608-263-1388
ST—John S Blackwood, MD
17050 W North Ave
Brookfield 53005
414-786-3722

Wisconsin Urological Society
P—Barry H Usow, MD
2901 W KK River Pkwy #370
Milwaukee 53215-3660
414-672-6006
ST--Frank P Begun, MD
9200 W Wisconsin Ave
Milwaukee 53226
414-259-2795❖

Publications available

A NUMBER OF BROCHURES are available from the SMS. Most are intended as patient-education materials on scientific and socioeconomic issues; others are useful as physician-education tools on socioeconomic and legislative topics. Some are available free of charge, while others require a nominal charge. State and local sales tax (5.5%) will be added. Call the SMS Division of Communications for more information (unless indicated otherwise): 1-800-362-9080, or in Madison, 257-6781.

Advanced CPT-4 Coding
This manual is intended for experienced coders and includes an intense series of advanced coding exercises designed to fine-tune coding skills. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Advanced ICD-9 CM Coding
This manual is designed for experienced coders. It will reinforce coding guidelines and sharpen ICD-9-CM coding skills to provide the highest quality diagnostic information needed to enhance reimbursement. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Anatomy and Physiology
This manual reviews the basics of body structure and function including both normal and pathological conditions. It provides a basic understanding of problems commonly encountered in health care settings and, combined with medical terminology, provides the foundation needed for accurate reimbursement coding and medical chart entries. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Basic CPT-4 Coding
This basic manual is designed for beginning coders. It stresses the rules and guidelines of the CPT-4 book. There are beginning level exercises stressing the fundamentals. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Basic ICD-9 CM Coding
This basic manual is designed for beginning coders. It stresses the importance of the ICD-9-CM system and introduces the guidelines necessary to use the system correctly. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Cardiovascular Coding for Physician Reimbursement
This manual is designed for advanced coders and addresses advanced level issues in both CPT-4 and ICD-9-CM unique to cardiovascular coding. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

CPT-4 Evaluation and Management Coding
This manual is designed to help coders understand the CPT-4 Evaluation and Management (E/M) codes. The manual contains exercises to stress the necessary information needed to use the E/M codes correctly. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Customer Service Enhancement for The 90's
This manual is designed to prepare you for the fast-paced 90s and teach you skills to keep patients coming back. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Facts About Malignant Melanoma
This patient education brochure explains who is most at risk, how to detect and prevent melanoma, and how to conduct a self-examination. Published in 1988. Contact Lynne Bjorgo, SMS Communications.

General Surgery Coding for Physician Reimbursement
This specialty manual is designed for advanced coders and provides instruction in general surgical coding including the importance of accurate CPT-4 and ICD-9-CM coding for optimal surgical reimbursement. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Health Insurance 101
This handbook is designed to introduce the basics of the health insurance industry. Emphasis is placed on basic health insurance terminology, benefit interpretation, types of contracts and resolving claim problems. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

If You Have a Complaint About Medical Care
This brochure explains the SMS's grievance and peer review system. Published in 1983. Contact Sonia Porter.

Intermediate CPT-4 Coding
This manual is designed for coders with a minimum of six months coding experience. It reviews the fundamentals and challenges the coder with a series of intermediate level problem-solving exercises to expand coding skills. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Intermediate ICD-9 CM Coding
The intermediate ICD-9-CM manual is designed for coders with a minimum of six months coding experience. It reviews the basic fundamentals of the ICD-9-CM coding system and focuses on the ICD-9-CM rules through a series of challenging exercises. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Legal Guidelines for Health Care Records
This manual is designed for medical group managers and office personnel and covers all aspects of medical records management. $25.00 + tax. Contact Elaine Stern, SMS Seminars

Office and Reception Skills
This handbook is designed for front office personnel. It gives instruction on scheduling appointments, telephone etiquette, reception skills and interaction with patients. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Medical Professional Liability Insurance: Claims Made or Occurrence?
This brochure explains for physicians how the policies work, how premiums are established, how coverage is terminated, the limits of liability and how to decide between the types of coverage. The brochure was produced by the SMS Young Physicians Section and is particularly useful for physicians just beginning their practice. Revised in 1992. Contact: Alice Ballweg at 1-800-545-0631, or in Madison, 283-5483.

Medical Terminology
This manual is designed to introduce basic medical

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Alliance President Helen Hacker (l) celebrates with her daughter Susan (c) and Maria Van Cleve, SMS Alliance Coordinator (r).

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terminology. There is an emphasis on terms commonly used for insurance claims and coding. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Medicare Part B Physician Reference Manual
This guidebook is designed to help the physician's billing staff stay on top of Medicare's policy and procedures. $49.00 + tax. Contact Elaine Stern, SMS Seminars.

OB/GYN Coding for Physician Reimbursement
This manual is designed for advanced coders and addresses issues in both CPT-4 and ICD 9-CM coding encountered in the OB/GYN practice. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Occupational Health Guide
This newly revised edition contains information for medical and nursing personnel in the commercial and industrial setting. Entitled "Your Body In The Workplace," the guide includes the Employee's Right to Know Law and the OSHA Bloodborne Pathogens Final Standards. Contact Jane Anderson, CES Foundation. Published in 1992.

Orthopedic Coding for Physician Reimbursement
This manual is designed for advanced coders and addresses issues unique to CPT-4 and ICD-9-CM orthopedic coding commonly used for insurance claims and coding. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

OSHA Reference Manual
This manual is an employer's guide to understanding the Occupational Safety and Health Administration Act. It deals with issues such as "Employee Workplace Rights," "Civil penalties applicable under OSHA," and much more. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

PartnerCare
A poster and brochure aimed at educating elderly low-income patients about this important SMS voluntary Medicare assignment program. Contact Tamara Larson.

A Physician's Guide to Wisconsin Health Law
This handbook deals with the more important legal and socioeconomic issues affecting the practice of medicine in Wisconsin. The information in this book will help you avoid pitfalls, answer your patients' questions, ask the right questions when you need counsel, and become a more involved and effective voice for the profession. Revised in 1993. Contact Lynne Bjorgo, SMS Communications.

A Practical Guide to Public Relations
This booklet is designed to assist Wisconsin's county medical societies enhance their public relations efforts in their own communities. Published in 1988. Contact Lynne Bjorgo, SMS Communications.

Questions and Answers on Smokeless Tobacco
This patient education brochure explains smokeless tobacco and its dangers in very plain language. Published in 1988. Contact Lynne Bjorgo, SMS Communications.

Skeletal Terminology
This manual will introduce basic medical terminology of the musculoskeletal system with an emphasis on the terms commonly used in coding bone and muscle injuries and diseases for coding on insurance claims. $25.00 + tax. Contact Elaine Stern, SMS Seminars.

Talking with Patients
A video and companion brochure designed to create and foster better communications between physician and patient. The video creates a dramatic "real life" situation to provide useful insights from both the physician's and patient's point of view. The cost is $14.95 per tape which includes postage and five copies of the brochure. Make checks payable to: CES Foundation, Attn: Jane Anderson, P.O. Box 1109, Madison, WI 53701.

The video was produced in 1992 by the Medical College of Wisconsin's Center for the Study of Bioethics with funding from the Charitable, Educational and Scientific Foundation of the SMS and the Wisconsin Hospital Association Research and Education Foundation, Inc.

UCR, A Patient's Guide: How Much Will My Health Insurance Pay?
This brochure explains what "usual, customary and reasonable" means, how misunderstandings concerning it can be avoided and how problems can be resolved when they occur. This brochure is suitable for enclosure in office statements or for placement in patient reception areas. Revised in 1993. Contact Lynne Bjorgo, SMS Communications.

Update REACH: Resource for Education Awareness of Community Health
Examining the changing nature of the public's image

of physicians and explaining SMS media policies and programs on current medical issues. Published in 1985. Contact Lynne Bjorgo, SMS Communications.

Vaccine Information
Anyone in the United States who administers the DTP, MMR, and Polio vaccines is required by law to provide parents with a brochure on the potential side effect and benefits of these immunizations before they are given. As a service, the American Academy of Pediatrics is providing these brochures at cost. In addition, these brochures are now available in Spanish. Pamphlets may be ordered in bulk from the American Academy of Pediatrics at a rate of $26 per 100 for non-members; $21 per 100 for members. Questions? Call 1-800-433-9016 or (708) 228-5005 (outside US and Canada).

Worker's Compensation
The SMS makes available to physicians several brochures and booklets designed to ease the burden of worker's compensation cases. Titles include: "How to Evaluate Permanent Disability," published in 1987; "Wisconsin Doctors and Worker's Compensation," published in 1987; and "Using the WC-16B for Worker's Compensation," published in 1986. Contact Lynne Bjorgo, SMS Communications.

Your Right to Direct Your Future Health Care
Facing questions on advance directives? The SMS now has pamphlets for patients explaining advance directives and medical treatment decision making. This easy-to-read, non-technical pamphlet will help you respond to the anticipated increase in patient questions about these issues as the result of a new law. As of Dec 1, 1991, all federally-certified nursing homes, hospitals, home health agencies, hospices, personal care agencies, and health maintenance organizations are required under the new federal Patient Self-Determination Act to provide written information to patients describing their rights regarding self-determination of medical care. As a result, many patients will be looking to their doctors for information. This brochure was developed by the Wisconsin Division of Health in cooperation with the SMS and other organizations. Published in 1991. Contact Lynne Bjorgo, SMS Communications.❖

Statewide Physician Health Program

The Statewide Physician Health Program (SPHP) functions under the purview of the Commission on Mediation and Peer Review, although its activities are managed by a seven-member managing committee. The program protocol guides the general handling of inquiries or concerns regarding potentially impaired physicians. Available to all Wisconsin licensed physicians, the program offers education, identification, assessment, and compassionate intervention. The program refers physicians to acceptable facilities for evaluation or treatment, and monitors a minimum two-year follow-up after completion of initial therapy. Through its efforts, many physicians have been encouraged by compassionate colleagues to enter structured rehabilitation.

Eighty percent of the physicians referred to SPHP are referred for suspected alcohol or other drug problems. Literature on the subject validates that from 10% to 14% of practicing physicians have difficulty with alcohol and drugs. Other concerns for which physicians may be referred to SPHP include psychiatric illness, physical illness, stress, and cognitive impairment.

Unfortunately, many people in a position to observe and identify impaired physicians do not know what to do when they perceive a problem, nor do they realize that help is available from organized programs. Furthermore, individuals such as medical staff members, hospital administrators, and others are reluctant to report a physician to an organized program. Their initial reaction is to not get involved, or to conclude that the problem can be handled by someone else in some other manner. This attitude often results in delayed intervention and treatment, or in passive action which ultimately fails.

Current techniques of identification, intervention, assessment, treatment, and follow-up of impaired physicians are not well known in the medical community. As a result, few are able to respond adequately when they accept an impaired physician as a patient.

Through efforts of the SPHP Managing Committee, the SMS Board of Directors approved con-

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tracting with a part-time medical director to provide continuous program leadership and activity. The SMS House of Delegates adopted the Board's recommendation and approved a $15 dues increase to fund the position.

Phase I: Education and prevention

Target individuals and groups are educated to understand physician impairment. They learn symptoms of impairment; techniques of early identification and prevention; and resources available for identification, assessment, intervention, and treatment; and social, financial, legal and other problems associated with impairment.

Primary target groups.

- Physicians: Meetings of hospital medical staffs, county medical societies, regional or statewide continuing medical education, and accredited seminars, (eg., at the SMS Annual Meeting).
- Hospital Personnel: Hospital administrators and medical directors, chiefs of medical staffs, hospital boards of trustees, directors of nursing and pharmacy, and others (eg, anesthetists and technicians). Consultation for medical staff officers on establishing effective impaired physician committees or programs in hospitals. "Guidelines for Physician Aid Committees of Hospital Medical Staffs" have been distributed to all Wisconsin general hospitals with encouragement to implement them in cooperation with medical staffs.
- Pharmacists, Nurses, and Nursing Home Administrators: Lectures at association meetings, or in combination with physician and hospital personnel meetings.
- Spouses and Families of Physicians: Educational material available at state and county medical society and auxiliary meetings.
- Legal Profession: Urge lawyers, whose state association has its own impaired lawyers program, to encourage their physician clients to use organized medicine's voluntary impaired physicians programs, when perceived needs arise.
- Teaching staff. Teaching staff presents educational and prevention programs to the various target groups.

Phase II: Intervention and treatment

Successful programs include the availability of physician interveners to perform compassionate colleague-to-colleague contact with physicians identified as impaired.

Approximately 35 trained physicians throughout Wisconsin are available to meet with and urge im-

WISPAC and Physicians for Better Government

The Wisconsin Physicians Political Action Committee (WISPAC) is a voluntary, nonprofit organization open to physicians and their spouses. Restricted from making political contributions, the SMS created WISPAC to provide the medical profession an opportunity to become more politically active and effective. WISPAC is governed by a board of directors, traditionally concentrates on state legislative races, and cooperates with the American Medical Political Action Committee (AMPAC) on federal issues.

Physicians for Better Government is a direct giver program, or political conduit, established in 1987 by the SMS. Political conduits differ from political action committees in that contributors retain the right to decide who receives their individual contributions. Physicians for Better Government contributions are deposited in a special account in each contributor's name. No contribution is made to a candidate without the contributor's authorization.

WISPAC and Physicians for Better Government are administered by the SMS Government Relations, pursuant to state statutes and administrative rules authorizing and regulating these programs. For additional information call 608-257-6781 or 1-800-362-9080.

Contributions may be sent to: Physicians for Better Government/WISPAC, PO Box 2595, Madison, WI 53701.

Suggested membership categories include:

- $500 Chairman's Club
- $200 Sustaining member
  ($100 Physicians for Better Government, $50 WISPAC, $50 AMPAC)
- $100 Sponsor
  ($50 Physicians for Better Government, $30 WISPAC, $20 AMPAC)

Contributions at the above levels authorize PFBG to transfer the amounts shown to WISPAC and AMPAC. If you wish to contribute differently, you may allocate amounts of your choice, per the examples below:

- $50 Physicians for Better Government only
- $50 WISPAC/AMPAC ($30 WISPAC, $20 AMPAC)❖

paired colleagues to leave the medical practice to enter suitable programs for evaluation and treatment. Programs considered suitable are those which comply with Statewide Physician Health Program requirements.

The initial intervention is always a compassionate encounter. The Wisconsin program has no interest in the punitive or coercive approach until all benevolent measures have been exhausted. An intervener's interests are the personal well-being of a colleague, and the quality of health care for patients.

The Statewide Physician Health Program has learned that physicians suffering from chemical dependency achieve a more satisfactory recovery status when they receive intensive treatment in facilities which espouse the medical model of therapy, under which the physician is seen by the physician addiction specialist on a frequent, if not daily basis. Within this model, the Program has established certain requirements for satisfactory primary treatment of chemical dependency.

Physicians suffering from emotional illness or senility, or from the sequelae of stress when these are uncomplicated by chemical dependency, will be encouraged to seek assessment and/or treatment through Statewide Program approved facilities or practitioners.

SPHP adheres to the policy that satisfactory recovery can only be realized through a monitored two-year recovery period. It considers the two years after initial treatment to be vital to assuring continued recovery.

Phase III: Benevolent assistance

In addition to the burdens of impairment, some physicians are financially unable to pay the cost of in-patient care. By estimate, at least 10% of Wisconsin impaired physicians have either no or inadequate health insurance. Some have been ill for so long that their financial resources essentially have been depleted. About 10% of the charges for rehabilitation of such physicians go unpaid. For 60% of chemically dependent physicians, residence and treatment in recovery homes (average of three months stay, at a cost of $5,000 per month) is essential for completion of the two-year recovery program.

With approval of the SMS and CES Foundation Boards of Directors, the Statewide Physician Health Program established a Physicians Benevolent Assistance Fund with pledges to the CES Foundation. The fund appeal among SMS members and Wisconsin hospitals was designed to develop a fund of $150,000 for low-interest loans to impaired physicians, who can potentially repay the loan(s) after returning to medical practice.

Phase IV: Protecting the public

The State Medical Society program maintains formal linkage with the Wisconsin Medical Examining Board (MEB) through the Coordinating Council on Physician Impairment. The Council consists of three physicians representing the State Medical Society and three members of the Medical Examining Board. The Council establishes guidelines for the Statewide Program and coordinates activities so that appropriate information is shared and Council action can be taken in the event a physician fails to respond to treatment or refuses to enter rehabilitation. The Council may refer a physician to the MEB in an instance where the health of the public may be jeopardized. The Council presents a desirable balance of concerns and interests between the voluntary assistance program of organized medicine and the state's statutory licensing and disciplinary body. Thus the Council is an appropriate step in the reporting process if necessary during attempts at physician rehabilitation where difficulty may be encountered.

Any responsible person concerned that a physician may suffer from an impairment may write to the Society or call (608) 257-6781 in Madison or 1-800-362-9080 in Wisconsin. Strict confidentiality is assured. Staff assigned to receive information will consult with the SPHP Medical Director for guidance and early action. All information is evaluated for accuracy. When it is determined that a potential problem exists, an intervener team is recruited to meet with the involved physician. From that point the process evolves which should assist the physician to recognize the impairment and to accept a treatment plan leading to recovery and a return to successful practice.❖

"I want to live."

Ashley has cancer. It sounds like such a grown-up disease, but each year, more than 6,000 American children will be stricken with cancer.

Ashley, and thousands of others like her, will have a chance to beat cancer because of the life-saving research and treatments developed at St. Jude Children's Research Hospital.

To find out more, call **1-800-877-5833.**

ST. JUDE CHILDREN'S RESEARCH HOSPITAL

Danny Thomas, Founder

SMS physician support program

The SMS Commission on Medical Liability and Risk Management created the Physician Support Program in 1987 to help physicians and their families cope with the stress of being sued for malpractice. The program provides emotional support, practical information, and an opportunity for the physician and spouse to share their feelings with sympathetic listeners.

How the program works

When a physician is sued for medical malpractice, the SMS sends him or her a packet of materials that includes a letter explaining the Physician Support Program, advice on coping with the experience, and a list of physicians and spouses who have volunteered to serve as members of a special support group. The packet also contains a description of the Medical Mediation Panel System and helpful materials for the physician's spouse.

The Physician support group

The purpose of the support group is to offer emotional support and practical advice for dealing with a medical malpractice suit. The emphasis is on personal contact and communication between the physician or spouse requesting help and the panel member. The setting of meetings is left entirely to the parties involved, and may be limited to telephone calls, if desired. Topics covered during meetings are expected to be wide ranging, (eg feelings of hostility, fear, loss of confidence, difficulty in making decisions, and withdrawal from the family) but discussions of the specific merits of the case are avoided. The emphasis is on individual interaction and open and frank discussions. There are no group sessions. Confidentiality is assured in all cases.

Any practicing physician who has been a respondent in a malpractice action and feels he or she can offer emotional support to a colleague in a similar situation is encouraged to volunteer as a support group member. Spouses who can provide support for their counterparts are also invited to participate. Each panelist receives basic information about the program and advice on how to be an effective participant.

Physicians interested in providing peer support through the Physician Support Program should contact Anne Bicha at the SMS.❖

Letter to physician named in a medical mediation case

Items mentioned in this letter as "enclosed" are available from Anne Bicha at the SMS.

Dear Doctor:

According to our records, you have been named in a medical mediation case. Feelings such as anger, frustration and depression are common for physicians involved in a malpractice action. I am writing this letter to inform you that there are other physicians and spouses who have been through similar experiences and are willing to discuss those feelings.

As part of the work of the State Medical Society Commission on Medical Liability and Risk Management, we have looked at the effect of the medical malpractice action on the physician and his or her family. It was the recommendation of the Commission on Medical Liability and Risk Management to the Board of Directors that the State Medical Society establish a support structure for physicians and their families involved in professional liability actions. Part of our proposal recommended the establishment of a group of physicians and spouses who could serve as "sympathetic listeners" for the physicians and their families involved in a liability action.

I invite you and your spouse or significant other to utilize the program. The SMS Auxiliary strongly supported the creation of the support group since it would be very beneficial to family members. Enclosed is a list of physicians and spouses who have volunteered to serve. Please feel free to contact any individual on the list. He or she will assure you of maintaining confidentiality.

Also, enclosed is a brief description of the program for you and your spouse, or significant other, and helpful materials to cope with the stress associated with medical litigation. Remember, talking to an experienced, knowledgeable peer about your frustrations is important. If you have questions about the program, please feel free to contact Anne Bicha at SMS, 800-362-9080 or (608) 257-6781.

Sincerely,

Sidney E. Johnson, MD
Chair, Commission on Medical Liability and Risk Management

Mediation and peer review services

When misunderstandings arise about what the physician hopes to accomplish and what the patient expects it is important that the patient discuss with the physician any questions about the medical care received. If they are not resolved, however, the SMS provides a means for resolving these differences.

The SMS Commission on Mediation and Peer Review receives, investigates, and resolves complaints and inquiries from patients and others, concerning Wisconsin physicians. The commission's standard of judgment is what constitutes good medical care. Physicians, too, may benefit from commission efforts to mediate differences between themselves.

Many complaints and questions received by SMS staff are resolved by telephone. By protocol, however, only written complaints will be considered by the commission. If all affected parties reside within the boundaries of a single county medical society, that society may assume jurisdiction of the complaint. If it does, the complaint will be transferred to the county medical society for investigation and resolution.

A protocol manual was developed by the Commission on Mediation and Peer Review and approved by the Board of Directors for conducting resolution of patient complaints, employing peer review mechanisms to test physician practice patterns, and responding to inquiries or requests for action regarding impaired physicians. The manual was designed to accommodate informal disposition of minor and uncomplicated complaints, as well as complex and serious matters which may involve due process, patient or physician appeals, proposed disciplinary actions, and Board of Directors consideration of a physician's SMS membership. The manual is available upon request.

Certain complaints received by the commission are evaluated by subcommittees, members of which submit reports and recommended resolutions to the commission chair. Frequently, these subcommittee conclusions are transmitted to the subject physicians, and as appropriate, to complainants. All subcommittee activities are reported to the commission. Matters of a more serious nature require additional use of the manual, as necessary.

The Commission on Mediation and Peer Review offers peer review services to private and governmental organizations and to physicians, including utilization review, appropriateness of patient care, and quality assurance. Although it is empowered to initiate disciplinary action, the commission's most valuable peer review benefits have been educational, judging from physician's expressed appreciation for the commission's consultation in matters of proper patient care.

The commission maintains purview over the Statewide Physician Health Program and continues its interest in the Coordinating Council on Physician Impairment of the SMS and the Medical Examining Board. The commission participates in the Medicaid Medical Audit Committee, under contract between the SMS and the Wisconsin Department of Health and Social Services.

Commission members will also review cases submitted by physicians who are the subject of Medicare or Medicaid reviews, to provide an independent assessment of the appropriateness of care provided. In those instances where the commission disagrees with a WIPRO or other review organization finding, the commission will provide the physician with independent medical opinion in any further action taken by the review agencies.❖

Rep Scott Klug discusses health system reform at the SMS annual meeting.

Accreditation program for continuing medical education

The SMS's accreditation program functions under the authority of the Accreditation Council for Continuing Medical Education (ACCME). Representatives from the American Board of Medical Specialties, American Medical Association, Association for Hospital Medical Education, Association of American Medical Colleges, American Hospital Association, Federation of State Medical Boards, and the Council of Medical Specialty Societies comprise the ACCME.

The SMS Commission on Continuing Medical Education currently reviews and accredits 55 hospitals, 20 specialty societies, two professional organizations, and one county medical society in Wisconsin. Information is available from Kristin Bjurstrom Krueger or Lisa Lawry at the SMS.

Category 1

Category 1 CME designated by an accredited sponsor must meet the following requirements:

- be sponsored by an organization accredited for continuing medical education by one of the state medical associations or by the Accreditation Council for Continuing Medical Education (ACCME), and
- be designated as AMA PRA Category 1 education by that organization.

Category 1 activities can take the form of lectures, seminars, use of self-study materials, self-assessment programs, mini-residencies, and use of audio-visual or computer based materials, so long as they are designated as AMA PRA Category 1.

Category 2:
All Other CME Activities

Education reported under Category 2 must meet the definition of continuing medical education and fit one of the descriptions of education provided below. Category 2 activities must also comply with the AMA "Ethical Opinion on Gifts to Physicians."

Non-Supervised Personal Learning Activities

- Clinical consultations that contribute to a physician's education.
- Informal educational consultations about a patient can be reported; these hours should be estimated and reported in hour blocks.
- Participation in patient care review activities.
- Teaching of medical and other health care professionals.
- Patient centered discussions with colleagues.
- Journal club activities.
- Use of self-assessment examinations and reviews.

The following Wisconsin organizations were accredited by SMSW and ACCME for continuing medical education programming as of June 1, 1994:

Accredited hospitals

Appleton Medical Center and St Elizabeth Hospital, Appleton
Bellin Memorial Hospital, Green Bay
Beloit Memorial Hospital, Beloit
Berlin Memorial Hospital, Berlin
Columbia Hospital, Milwaukee
Community Memorial Hospital, Menomonee Falls
Fort Atkinson Memorial Hospital, Fort Atkinson
Gundersen Medical Foundation, Ltd and La Crosse Lutheran Hospital, La Crosse
Hartford Memorial Hospital, Hartford
Howard Young Medical Center, Woodruff
Kenosha Hospital and Medical Center, Kenosha
Lakeland Medical Center, Elkhorn
Langlade Memorial Hospital, Antigo
Luther Hospital, Eau Claire
Memorial Hospital of Iowa County, Dodgeville
Memorial Hospital at Oconomowoc, Oconomowoc
Mendota Mental Health Institute, Madison
Mercy Hospital, Janesville
Mercy Medical Center, Oshkosh
Meriter Hospital, Madison
Reedsburg Memorial Hospital, Reedsburg
Ripon Memorial Hospital, Ripon
Riverside Memorial Hospital, Waupaca
Sacred Heart Hospital, Eau Claire
Sacred Heart-St Mary's Hospital, Inc, Rhinelander
Sauk Prairie Memorial Hospital, Prairie du Sac
Shawano Community Hospital, Shawano
Sheboygan Memorial Medical Center, Sheboygan
Sinai Samaritan Medical Center, Milwaukee
St Agnes Hospital, Fond du Lac
St Catherine's Hospital, Kenosha
St Clare Hospital, Baraboo
St Clare Hospital, Monroe
St Francis Hospital, Milwaukee
St Francis Medical Center, La Crosse
St Joseph's Community Hospital, West Bend
St Joseph's Hospital, Chippewa Falls
St Joseph's Hospital, Milwaukee
St Joseph's Hospital & Marshfield Clinic, Marshfield
St Luke's Hospital, Milwaukee
St Mary's Hospital, Milwaukee
St Marys Hospital Medical Center, Madison
St Mary's Hospital-Ozaukee, Mequon
St Michael Hospital, Milwaukee
St Michael's Hospital, Stevens Point
St Vincent Hospital, Green Bay
Stoughton Hospital Association, Stoughton

Theda Clark Regional Medical Center, Neenah
Trinity Memorial Hospital, Cudahy
Veterans Administration Medical Center, Tomah
Watertown Memorial Hospital, Watertown
Waukesha Memorial Hospital, Waukesha
Wausau Hospital Center, Wausau
West Allis Memorial Hospital, West Allis
Winnebago Mental Health Institute, Winnebago

Accredited specialties
American Cancer Society, Wisconsin Division
American Heart Association of Wisconsin
Fox Valley Academy of Medicine
Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
Racine Academy of Medicine
Wisconsin Academy of Family Physicians
Wisconsin Allergy Society
Wisconsin Association for Perinatal Care
Wisconsin Neurological Society
Wisconsin Psychiatric Association
Wisconsin Society of Anesthesiologists
Wisconsin Society of Obstetrics and Gynecology
Wisconsin Society of Otolaryngology--Head and Neck Surgery
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society
Wisconsin Urological Society

Accredited county medical societies
Marinette-Florence County Medical Society

Other accredited organizations
Physicians Insurance Company of Wisconsin
WIPRO
Wisconsin Association of Medical Directors

ACCME accredited
Medical College of Wisconsin
UW Center for Health Sciences
Interstate Postgraduate Medical Association
State Medical Society of Wisconsin❖

Membership facts

WHETHER YOU ARE JUST STARTING medical school, engaged in postgraduate training, maintaining a full-time practice, or retired, the SMS has a membership classification to fit your needs. Election to membership by the county medical society in which your principal place of practice is located carries with it membership in the SMS and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. You may also qualify for reduced dues during the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Regular membership dues in 1995 are $650 for the SMS and $420 for the AMA; county society dues vary.

Dues for regular, part-time practice, or over-age-70 membership classifications may be paid in one lump sum or in two equal installments, with the first half due by Oct 1, 1994, and the second half by Jan 1, 1995.

An incentive plan is available for early payment of county and state dues: $25 off state dues for those regular members who pay state and county dues in full by Oct 1, 1994.

A more detailed list of SMS membership classifications and their corresponding dues follow.

SMS Membership classifications
Regular: Member in active practice. Regular members who are in their first or second year out of residency, fellowship, or military obligation may qualify for reduced dues for the SMS, the AMA, or both.
Part-time practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year, but does not qualify for retired membership.
Resident: Member who as of Jan 1 of the dues year is in an approved training program as a hospital resident or research fellow and is licensed to practice medicine and surgery in Wisconsin.
Military service: Member who is serving in the US armed forces or US Public Health Service (generally not to exceed 5 years).
Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.
Retired: Member who has completely retired from

Continued on next page

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practice (works less than 240 hours each year). All dues are waived unless county society indicates it wishes to charge county dues. (Retired and life members who wish to receive *Medigram* and the *Wisconsin Medical Journal* must pay a $45 publications fee.)

Life: Member who has held membership in a state medical society for 50 years. Past presidents of the SMS are also included in this category.

Honorary: Physician named an honorary member by the Board of Directors for outstanding contributions to the medical profession.

Over age 70: Member in active practice who is over 70 years of age.

Scientific fellow: Person engaged in teaching or research in the basic sciences at an accredited college or university--but not holding a degree in medicine or osteopathy--by invitation and consent of the Board of Directors.

Emeritus: Retired member who has chosen not to renew his or her license, at the discretion of the Board.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

1995 Dues

	SMS	*AMA*	*County*
Regular	$650	$420	Varies
First year in practice	$325	$210	Varies
Second year in practice	$487	$315	Varies
Two physician family	$600	$420	Varies
Part-time practice	$325	$420	Varies
Part-time over age 70	$325	$210*	Varies
Resident	$ 85	$ 45	Varies
Military service	-0-	$280/$45	Varies
Associate	-0-	-0-	-0-
Retired	-0-	$420/$84/-0-*	Varies
Retired, over age 70	-0-	-0-	Varies
Life	-0-	$420/-0-*	-0-
Honorary	-0-	$420/-0-*	-0-
Over age 70	$325	$420/-0-*	Varies
Scientific Fellow	-0-	-0-	-0-
Emeritus	-0-	-0-	-0-
Candidate:			
Student	$ 10	$ 20	$2.50
Postgraduate-one	$ 10	$ 45	Varies

*Physicians in these categories may be eligible for exemption from AMA dues under the grandfather clause. (AMA dues-exempt members who were granted exemption before 1986 based on previously established criteria, with the exception of financial hardship or disability, will automatically be exempt from dues in 1986 and the years following.)

Current AMA policy provides for only two categories of exemptions: financial hardship or disability and 65 years of age or older and fully retired. AMA dues for under-age-65 and fully retired members may be reduced to $84.

State society dues are prorated on a monthly basis for those elected to membership July 1 through Aug 31. Those elected after Aug 31 are exempt from dues for the balance of the year in which they are elected. AMA dues are prorated on a semiannual basis.

To begin the membership process, contact your county medical society or call the Membership Department of the SMS at 1-800-362-9080 or 608-257-6781.❖

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Ben Wedro, MD, reports to the 1994 House.

SMS officers and directors by district

Officers of the Society
President (1994-1995)
Richard G Roberts, MD, 777 S Mills St
Madison 53715

President-elect (1994-1995)
Marcia J S Richards, MD
2900 W Oklahoma Ave, PO Box 2901, Milwaukee
53201-2901

Executive Vice President & Secretary (1994-1995)
Thomas L Adams, CAE, 330 E Lakeside St
PO Box 1109, Madison 53701

Treasurer (1994-1995)
Harry J Zemel, MD, PO Box 962
Fond du Lac 54936-0962

Board of Directors
Chair: Richard H Ulmer, MD
Vice Chair: Raymond C Zastrow, MD

District 1
Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, and Waukesha counties

Robert F Purtell, Jr, MD (1989/1992-1995)
3316 W Wisconsin Ave, Milwaukee 53208

Thomas A Reminga, MD (1986/1992-1995)
330 E Kilbourn, Ste 730, Milwaukee 53202

Raymond C Zastrow, MD (1987/1992-1995)
2400 W Villard Ave, Milwaukee 53209

Clarence P. Chou, MD (1994-1996)
10028 North Miller Dr, Mequon 53092-6186

Timothy G McAvoy, MD (1990/1993-1996)
1751 East Main, Waukesha 53186

Marvin G Parker, MD (1990/1993-1996)
1525 Howe St, Racine 53403

Charles E Pechous, Jr, MD (1990/1993-1996)
7202 Third Ave, Kenosha 53143-5509

John E. Ridley, III, MD (1990/1993-1996)
2315 N Lake Dr, Ste 1001, Milwaukee 53211

Jay F Schamberg, MD (1991/1993-1996)
8901 W Lincoln St, West Allis 53227

George R Schneider, MD (1989/1994-1997)
9330 W Lincoln Ave, West Allis 53227

Frank H. Urban, MD (1993/1994-1997)
3645 Emberwood Dr, Brookfield 53005

District 2
Adams, Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Marquette, Richland, Rock, and Sauk counties

John D Wegenke, MD (1986/1992-1995)
345 W Washington Ave, Madison 53703

Andrew B Crummy, Jr, MD (1992/1993-1996)
D4/348 UW CSC, 600 Highland Ave, Madison 53792

Cyril M Hetsko, MD (1993/1994-1997)
1313 Fish Hatchery Rd, Madison 53715

Jerry M Ingalls, MD (1992/1994-1997)
515 22nd Ave, Monroe 53566

Ayaz M Samadani, MD (1991/1994-1997)
P.O. Box 678, 148 Warren St
Beaver Dam 53916

Paul A Wertsch, MD (1993/1994-1997)
4221 Venetian Ln, Madison 53704

Continued from preceding page
District 3
Buffalo, Crawford, Jackson, Juneau, La Crosse, Monroe, Trempealeau, and Vernon counties

Mark H. Andrew, MD (1992/1992-1995)
125 W Jefferson, Viroqua 54665

Jack M Lockhart, MD, (1989/1992-1995)
1836 S Ave, La Crosse 54601

District 4
Clark, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, and Wood counties

William E Raduege, MD (1986/1992-1995)
PO Box 1387, 311 Elm St, Woodruff 54568

Richard H Ulmer, MD (1986/1992-1995)
1000 North Oak Ave, Marshfield 54449

Robert J Jaeger, MD (1988/1994-1997)
3291 Thompson Court, Stevens Point 54481

District 5
Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago and counties

James L Basiliere, MD (1986/1992-1995)
414 Doctors Court, Oshkosh 54901

Terry L Hankey, MD (1993/1993-1996)
900 Riverside Drive, Waupaca 54981

Harry J Zemel, MD (1987/1994-1997)
P.O. Box 962, Fond du Lac 54936-0962

District 6
Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, and Sheboygan counties

Stephen D Hathway, MD (1989/1992-1995)
PO Box 574, Green Bay 54305

John E Kraus, MD (1986/1992-1995)
100 Park St, Marinette 54143

David J Deubler, MD (1994/1994-1997)
635 Paine St, Kiel 53042

District 7
Barron, Chippewa, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St Croix, Burnett, and Washburn counties

Lloyd R Cotts, MD (1992/1992-1995)
2765 16th St, Rice Lake 54868

Charles V Ihle, MD (1994/1994-1997)
1325 Bittersweet Rd, Eau Claire 54701

District 8
Ashland, Bayfield, Douglas, Iron, and Sawyer counties

Robert L Sellers, MD (1987/1993-1996)
69 N 28th St, Superior 54880

Officers of the Society

President: Richard G Roberts, MD (1994-1995)
777 S Mills St, Madison 53715

President-elect: Marcia J S Richards, MD (1994-1995)
2900 W Oklahoma Ave, PO Box 2901, Milwaukee 53201-2901

Immediate past president: Pauline M Jackson, MD (1994-1995)
1836 South Ave, La Crosse, 54601

Speaker: Sandra L Osborn, MD (1993/1993-1995)
2085 County Rd J, Verona 53593-8829

Vice speaker: (1994/1994-1996)
Michael C Reineck, MD (1994/1994-1996)
1201 Oak St, West Bend 53095

Ex officio, without vote
Executive Vice President & Secretary Adams
Paul Bullis, Medical Student, UW-Madison
Michael Bigelow, Medical Student, Medical College of Wisconsin

Delegates to the AMA
John K Scott, MD (1979/1993 & 1994)
20 S Park St, #350, Madison 53715
Patricia J Stuff, MD (1979/1993 & 1994)
401 Mill St, Bonduel 54107
Timothy T Flaherty, MD (1988/1994 & 1995)
547 E Wisconsin Ave, Neenah 54956
John D Riesch, MD (1988/1994 & 1995)
PO Box 427, Menomonee Falls 53051
Kenneth M Viste, Jr, MD (1993/1994 & 1995)
100 Stoney Beach Rd, Oshkosh 54901
Cyril M Hetsko, MD (1994/1995 & 1996)
1313 Fish Hatchery Rd, Madison 53715
John P Mullooly, MD (1991/1995 & 1996)
8430 W Capitol Dr, Milwaukee 53222
Richard H Ulmer, MD (1994/1995 & 1996)
1000 N Oak Ave, Marshfield 54449

Alternate Delegates to the AMA
Cyril M Hetsko, MD (1983/1993 & 1994)
1313 Fish Hatchery Rd, Madison 53715
Richard H Ulmer, MD (1983/1994)
1000 N Oak Ave, Marshfield 54449
J D Kabler, MD (1982/1994 & 1995)
5501 Varsity Hill, Madison 53705
Susan L Turney, MD (1993/1994 & 1995)
1000 N Oak Ave, Marshfield 54449
Kevin T Flaherty, MD (1994/1995)
PO Box 689, 614 First St, Wausau 54402-0689
Jerome W Fons, Jr, MD (1988/1995 & 1996)
3734 W Coldspring Rd, Greenfield 53221
Kevin A Jessen, MD (1994/1995 & 1996)
1112 Charles Dr, Tomah 54660
Robert F Purtell, Jr, MD (1991/1995 & 1996)
3316 W Wisconsin Ave, Milwaukee 53208

Young Physicians Section Delegates to the AMA
Kevin T Flaherty, MD (1992/1992-1994)
PO Box 689, 614 First St, Wausau 54402-0689
Paul J Leehey, III, MD (1993/1993-1994)
1836 S Ave, La Crosse 54601

YPS Alternate Delegate to the AMA
Sheldon A Wasserman, MD (1993/1993-1995)
2388 N Lake Dr, Milwaukee 53211

NOTE: Officers, directors, delegates, alternate delegates, and members of commissions are elected at the annual meeting (April 1995). Dates in parentheses indicate initial year of appointment and beginning and expiration of terms of office. AMA delegates and alternate delegates' terms of office are on a calendar basis, although elected at the annual meeting.❖

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Expense reimbursement policy and procedure for physicians on SMS business

It is SMS policy to offer reimbursement of out-of-pocket expenses incurred by its officers, directors, committee chairs and members, AMA delegates and alternates and other designated physicians when such expenses are incurred in the course of the conduct of business on behalf of the society. The society recognizes that any such leadership role requires a substantial contribution in personal time on the part of the physician. Traditionally, this has been accepted as a contribution to the profession and the health of the public. Out-of-pocket expenses in the discharge of official functions of the society are, however, reimbursable as set forth below, except that district directors are not reimbursed for the expense of attending the annual meeting of the society (Bylaws, Chapter V, Sec 4).

Officers, directors, committee chairs and members, and other designated persons

Reimbursable expenses include the cost of:

- All meals, including normal tips, incurred while away from the physician's home city on SMS business.
- All meals in the home city of the physician when these are in relation to an SMS business meeting.
- Entertainment expenses where such expense is clearly a proper and necessary adjunct to the conduct of the physician's business function for the society.
- Valet and laundry services when the physician is away from home city on SMS business continuously for 4 days or more.
- Lodging for those days (nights) reasonably associated with the dates of a meeting for which expenses are claimed.
- Transportation from home city to meeting site and return as follows:
  Air. Cost of round trip coach airfare, plus necessary ground transportation.
  Bus or train. Cost of round trip fare, plus necessary ground transportation.
  Auto. Mileage at the current SMS rate (now $.29) to and from the meeting site, plus necessary parking fees and highway tolls.
  Miscellaneous ground transportation. Local bus and cab fares as necessary.
  Auto rental. All or some portion of such cost may be reimbursed as a substitute for other ground transport when this is the most feasible alternative following initial air, bus or train travel.
- Telephone, fax and telegraph communications relative to SMS business.
- Secretarial and copying services, postage and stationary used for SMS business. (Note: SMS headquarters is prepared to handle most official correspondence and reproduction work for officers and committee members. Physicians may be reimbursed, however, for personal or office costs relating to secretarial, copying, postage and stationery used in conducting SMS business. Copies of all official correspondence should be sent to the appropriate committee staff person at SMS, so as to assure proper coordination and record-keeping.
- Expenses, as described above, incurred by the president's and president elect's spouses when accompanying in an official capacity, or when the spouse is expected to be in attendance, are reimbursable.

Procedure for claiming expenses. To obtain reimbursement, submit a statement of expenses incurred within ninety (90) days from the date the expenses were incurred. Attach copies of bills or receipts for all lodging, travel, and meals over $25. Itemize separately costs for the eighth item above. Mail to SMS Business Services and Support, PO Box 1109, Madison, WI 53701. Reimbursement will be made within two weeks following receipt and approval of the expense report. Expense statements received after the 90-day period will not be reimbursed.

AMA delegates and alternates

AMA delegates and alternates (including the young physicians delegate and alternate) from Wisconsin receive reimbursement as follows for each meeting to the AMA House of Delegates they attend:

- Round trip economy air fare (advance booking strongly suggested.)
- Actual cost of room (mid-range) for 5 nights at the annual meeting, and 4 nights at the interim meeting.
- A per diem (currently $60) for food and all incidentals for 6 days at the annual meeting, and 5 days at the interim meeting.
- When AMA delegates and alternates are conducting SMS business not in conjunction with meetings of the AMA House of Delegates, their expenses may be reimbursed in the same manner as outlined for officers and directors.

Out-of-state trips

To receive reimbursement for out of state travel members must have prior approval by the Chairman of the Board of Directors and the Executive Vice President. Travel to the AMA House of Delegates meetings by the above mentioned and travel by the SMS President and President Elect are exempt from this policy.❖

SMS financial report

The following financial statements of the State Medical Society of Wisconsin are part of the treasurer's report to the House of Delegates. The annual certified audit, prepared by Grant Thornton, independent certified public accountants, is on file at Society headquarters. Members may review the audit by inquiry to the SMS executive vice president.

Balance sheet
Dec 31, 1993

Assets	
Current assets	
Cash and cash equivalents	$ 3,948,281
Investments	1,094,898
Accounts receivable	
Trade	45,040
Due from affiliates	95,838
Investment revenues receivable	3,715
Inventories	5,000
Prepaid expenses	63,796
Total current assets	$ 5,256,568
Property and equipment—at cost	
Building and equipment	$ 2,590,819
Furniture and equipment	1,235,472
Capitalized lease equipment	225,820
Less accumulated depreciation	(1,992,961)
Land	69,968
Total property and equipment	$ 2,129,118
Other assets	
Rental property, net of accumulated depreciation	$ 1,501,329
Prepaid pension costs	158,371
Long-term investment	249,000
Cash value of life insurance	2,579
Investment in subsidiary	187,783
Deferred compensation plan assets	326,543
Notes receivable	100,000
Total other assets	$ 2,525,605
Total assets	$ 9,911,291
Liabilities	
Current liabilities	
Current maturities of long-term debt	$ 1,089,892
Trade accounts payable	111,341
Dues payable to other organizations	910,483
Accrued payroll and vacation pay	105,700
Accrued property, payroll and sales taxes	177,633
Deferred revenues	2,865,908
Accrued health plan costs	11,772
Other	28,750
Total current liabilities	$ 5,301,479
Long-term debt less current maturities	$ 828,151
Deferred compensation payable	$ 328,505
Membership equity	$ 3,453,156
Total liabilities and membership equity	$ 9,911,291

Statement of income and expenses
Year ended Dec 31, 1993

Income	
Membership dues	$ 3,374,747
Sales and services	1,298,833
Investment income	131,906
Royalty income	291,703
Gain on investments	255,111
Rental	246,203
Other grants	36,020
Other	12,471
Total income	$ 5,646,994
Expenses	
Payroll and employee benefits	$ 2,668,748
Travel and conference	584,807
General and administrative	1,107,130
Occupancy	396,915
Professional fees and outside services	309,033
Pension amortization	142,805
Interest expense	183,048
Other	5,342
Total expenses	$ 5,397,828
Excess of revenues over expenses	$ 249,166
Equity at Jan 1, 1993	$ 3,326,987
Equity in loss of subsidiary	$ (122,997)
Equity at Dec 31, 1993	$ 3,453,156

❖

Charter law of the SMS

Chapter 148

148.015 State society.(1) The State Medical Society of Wisconsin is continued with the general powers of a corporation. It may, from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 County societies. (1) The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists, may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the medical examining board, shall be entitled to meet for organization or become members of the county medical society.

(3) If there is not a sufficient number of physicians and surgeons in any county to form a county medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than 15 adjoining counties may organize a county medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 Service insurance corporations for health care. The state medical society or, in a manner approved by the state society, a county society, may establish in one or more counties of this state a service insurance corporation for health care under ch. 613.

Note on §148.03, 447.13, and 449.15: Chapter 613 provides in general terms for the creation, governance and regulation of service insurance corporations for any kind of health care, as well as for other types of services. All that is needed in each authorizing chapter for professional societies is a brief section giving the appropriate professional society the power to organize a ch. 613 corporation. Section 148.03 creates that section for health care.

One basic restriction results from the repeal of the old enabling sections: none of the professional societies will be able to organize a service insurance plan within its own corporate structure. It is a mistake to permit such a mixing of professional and insurance activities within the same corporation. The society can, of course, control the service insurance corporation it creates under ch. 613, but the service insurance corporation will be legally separate. This will lead to more effective (and appropriate) control by the insurance commissioner, who should neither be empowered nor compelled, as arguably he was under the old statutes, to have any concern about the purely professional activities of the societies, because of the impossibility of disentangling the insurance and professional activities carried on by a single corporation.❖

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SMS Constitution and Bylaws

Constitution

Article I
Name of the association

The name and title of this organization shall be the State Medical Society of Wisconsin.

Article II
Purpose

The purpose of the Society is to bring together the physicians of the state of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws. As used in the Constitution and Bylaws, "physician" means a doctor of medicine or a doctor of osteopathy licensed in Wisconsin.

Article III
Component societies

Component societies shall consist of those county medical societies chartered by the House of Delegates of this Society.

Article IV
Composition of the association

This Society shall consist of members who shall be the members of and certified by the component county medical societies; and whose dues and assessments for the current year have been received by the Society executive vice president in accordance with the schedule provided in the Bylaws.

Article V
House of Delegates

The House of Delegates shall be the legislative body of the Society and shall consist of:

(1) delegates elected by the component county medical societies,
(2) one delegate representing each specialty section of the Society organized under the Bylaws,
(3) a speaker,
(4) a vice speaker.

The officers of the Society enumerated in Article IX of this Constitution, directors, and past presidents of the Society shall be ex officio members, but without the right to vote, except that if they have been duly seated as delegates, they shall have the right to vote. The speaker and vice speaker shall be elected by and from the House of Delegates for two-year terms, and shall be limited to three consecutive full terms in their respective offices. While holding these offices, they shall be members of the House at large and shall not represent any component county society or specialty society.

Article VI
Board of Directors

The Board of Directors, hereinafter referred to as "Board," shall have full authority and power of the House of Delegates between sessions of the House. It shall consist of the directors, immediate past president, president, president-elect, treasurer, speaker and vice speaker of the House of Delegates. The executive vice president shall be an ex officio member of the Board, but without the right to vote. A majority of its voting members shall constitute a quorum. Directors shall be elected from eight geographic districts whose boundaries shall be determined by the House of Delegates. There shall be elected one director from each district. In addition, there shall be elected director(s) from each district based on a formula using the number of members in each district as the numerator and the total membership of the Society as the denominator, rounded to the nearest whole number. This calculation shall be made every third year, and, as nearly as possible, is to provide for no more than 31 district directors and shall be based on the year end membership totals. The number of directors established for each district shall be approved by the Board and shall be reported to the districts by the executive vice president before annual elections to the Board. As nearly as possible, one-third of the members of the Board shall be elected each year. Each director shall be nominated and elected only by the elected delegates of the county medical society of societies from the district in which the director's principal place of practice is located. Such election shall be subject to the approval and confirmation of the House of Delegates. The terms of the directors shall be for three years. No individual shall be permitted to serve more than three consecutive three-year terms as director, and no more than a total of six terms of service as director shall be permitted.

Adopted as amended by the House of Delegates, April 15, 1993.

Article VII
Specialty sections

The House of Delegates shall provide for a division of the Society into specialty sections.

Article VIII
Meetings

Section 1. The Society shall hold an annual meeting, at which time the House of Delegates shall meet to conduct its business. The annual meeting may also include scientific sessions as determined by the Board.

Sec 2. The place for holding each annual meeting shall be fixed by the House of Delegates, or by failure to act, such authority is delegated to the Board. The time and the place for holding each annual meeting shall be approved by the Board.

Sec 3. Special meetings of the House of Delegates shall be called by the speaker on written request of twenty delegates representing at least 10% of the component county medical societies, or on request of a majority of the Board. When a special meeting is called, the speaker shall set the time and place. The executive vice president shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the date of the special meeting. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall consider no business except that for which it is called.

Article IX
Officers

Officers of this Society shall be a president, a president-elect, an executive vice president, and a treasurer. The president-elect and treasurer shall be elected annually by the House of Delegates. The executive vice president shall be elected and the treasurer shall be nominated annually by the Board. The president-elect shall automatically succeed to the office of president at the conclusion of the term as president-elect. The treasurer shall be limited to nine consecutive terms and must be a director of the Board. No person shall hold more than one of the following offices concurrently: president, president-elect, executive vice president, treasurer, speaker, vice speaker, director, except that the treasurer is a member of the Board. Incumbents shall serve until their successors are elected and installed.

Article X
Funds and expenses

Funds may be raised by annual dues or by assessment on the members, or in any other manner approved by the House of Delegates. The House may establish regular and special classifications of membership. Dues, if any, shall be applied equitably to all members in each class. All resolutions adopted by the House of Delegates providing for appropriations shall be referred to the Board for implementation. All expenditures approved by the Board shall be included in the annual budget.

Article XI
Referendum

The House of Delegates may, by a two-thirds vote of those registered at that session, submit any question to the membership of the Society for its vote, except amendments to the Constitution. Such amendments are governed by Article XIII. The House shall determine prior to submission whether a referendum shall be advisory or binding, and so advise the membership at the time of submission. A majority vote of all the members of the Society shall determine the question on a binding referendum.

Article XII
Seal

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

Article XIII
Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual meeting, provided that such amendment shall have been introduced in the form of a constitutional amendment in open session at the previous annual meeting, and that it shall have been published at least once during the year in the Journal of this Society, or sent to each member of the Society at least two months before the meeting at which final action is to be taken.

Bylaws

Chapter 1
Membership

Section 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of the county society, shall be prima facie evidence of membership and of the right to benefits.

Sec 2. No person whose name has been dropped from the roll of members of a component society or this Society shall be entitled to any of the rights or benefits of this Society, except that such rights and benefits shall continue during the period of an ap-

peal by such person to the Board of Directors.

Sec 3. Every physician who holds a license to practice medicine and surgery in Wisconsin shall be eligible to apply for membership. Each county society shall be the judge of the initial and continuing qualifications of its members, as well as the appropriate membership classification, subject to review and final decision by the Board of this Society. Members will conduct themselves in a manner which is not in conflict with the purposes for which the Society is organized and is operating.

Sec 4. By provision of its constitution or bylaws, a county society may require that an applicant shall have practiced within its jurisdiction for a period of one year as a condition for election to membership; or that an applicant may first be elected to membership for a term of one year only, then resubmit to election by vote of the county society without limitations as to term.

Sec 5. A member of a component society whose license has been revoked, suspended, non-renewed, or voluntarily surrendered, shall be immediately and automatically suspended from membership as of the date of revocation, suspension, non-renewal, or voluntary surrender, pending definitive action by the Board.

Sec 6. A physician's county society membership must be held in that county in which the physician's principal practice is located. However, a physician living near a county line may hold membership in that county most convenient for attending meetings, with concurrence of the component society in which the principal place of practice is maintained.

Sec 7. A member whose principal practice is moved from within the territorial limits of a component medical society to the territory of another component of the State Society shall not be eligible to continue membership in the first such society after the expiration of the calendar year in which such move shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society into whose jurisdiction the principal practice has been moved. The member shall be given a written certificate of transfer for transmission to the secretary of the society in the county to which he has moved. Pending acceptance or rejection by the society in the county to which he has moved, such member shall be considered to be in good standing in the first society and in the State Society until the end of the period for which dues have been paid.

Sec 8. When the principal practice of a member in good standing in a component society is moved outside the borders of this state, active membership in such component society and in the State Society may be continued by fulfilling all requirements of membership except residence pending acceptance as a new or transfer member by the society of the area to which the practice has been transferred. The period of such continuing membership in this state shall cease upon acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which the practice location has been transferred.

Sec 9. Membership classifications. Members defined in this section, except affiliates, shall have all the rights and privileges of the Society and shall pay dues and assessments, as indicated, as a requirement of continued membership.

A. *Regular.* Regular members of this Society consist of all the regular members in good standing of the component county societies.

B. *Special.* Included in this classification are the following categories of members who by virtue of their special circumstances are entitled to reduced dues or waiver thereof:

(1) *Part-time practice.* Any physician, regardless of age, who practices 1,000 hours or less during a calendar year, but does not qualify under section 9.B.(5), may upon application, recommendation by the county medical society, and approval by this Society, be placed in this special category.

(2) *Resident.* Physicians in approved training programs as hospital residents or as research fellows who are licensed to practice medicine and surgery in Wisconsin. Such special membership category can be maintained for a maximum of five (5) consecutive years.

(3) *Temporary Military Service.* Members who are inducted into the United States Military or Public Health Service and serve in such capacity for not more than five (5) years.

(4) *Associate.* Members who suffer a disability preventing them from practicing medicine with resulting serious financial reverses which would make the payment of dues a matter of personal hardship. Such membership shall be on an annual basis, upon recommendation of the county society and approval by the Board of this Society.

(5) *Retired.* Members who have retired completely from the practice of medicine, or who practice 240 hours or less during a calendar year, upon recommendation of the county society and approval by this Society.

(6) *Life.* Those members of the State Medical Society of Wisconsin who have been members of this or other state medical societies for fifty (50) years, or are past presidents of the State

Medical Society of Wisconsin. They shall receive a certificate of Life Membership.

(7) *Honorary.* Members who have been elected to a similar classification by their county society because of outstanding contributions to the medical profession, upon approval by the Board of this Society.

(8) *Over Age 70.* Members who are age 70 effective January 1 of the following year.

C. *Affiliate.* Persons who are not otherwise eligible for membership may become affiliated with this Society in one of the following categories. Their dues or assessments, as well as rights and privileges as affiliate members, shall be determined by the Board.

(1) *Candidate.* Upon application, a county medical society or this Society may confer upon any person then attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure the status of Candidate Member.

(2) *Scientific Fellow.* The Board may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

(3) *Emeritus.* Retired members who have chosen not to renew their license, at the discretion of the Board.

Sec 10. Dues and Assessments. Members shall pay dues and assessments as follows:

A. *Regular members:* full dues and assessments.

B. *Physicians in part-time practice or over age 70:* one-half of regular member dues and assessments.

C. *Physicians in residency or fellowship training:* dues and assessments are to be determined by the Board of Directors. Dues and assessments for all other categories shall be waived, except as may be determined by the Board for affiliate members.

Chapter II
House of Delegates

Section 1. Each component county society shall be entitled to send one delegate and one alternate to the House of Delegates for each forty regular and special members or majority fraction thereof in this Society, provided, however, that each county society shall be entitled to at least one delegate and one alternate from that county society. For purposes of this section, the number of members as of the close of the calendar year preceding the first session of the House of Delegates at the Annual Meeting shall determine the number of delegates to which a county society shall be entitled. The secretary of each county society will send a list of such delegates and alternates to the executive vice president of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve.

Sec 2. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

Sec 3. The speaker shall preside at the meetings of the House of Delegates.

Sec 4. The vice speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice speaker shall officiate during the unexpired term.

Sec 5. The speaker shall appoint members of reference committees from among the members of the House of Delegates. These committees shall consider and make recommendations to the House relative to resolutions, reports of officers, reports of commissions and committees, financial and other matters germane to the business of the House. The speaker shall also appoint a credentials committee and such other committees as deemed necessary.

Sec 6. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body. No person who has served 12 or more consecutive years as a Wisconsin delegate to the AMA shall be eligible to serve another term unless the delegate will concurrently serve on any of the following American Medical Association Councils: Constitution and Bylaws, Medical Education, Medical Service, Ethical and Judicial Affairs, Long Range Planning and Development, Legislation, Scientific Affairs; or, the American Medical Political Action Committee Board of Directors.

Sec 7. The House of Delegates shall have authority to create committees for special purposes and to appoint members of the Society who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and their members may be present to participate in the debate on their reports.

Sec 8. It shall receive for appropriate action the annual reports of the treasurer, executive vice president, and chair of the Board of Directors.

Sec 9. Unanimous consent of the House of Delegates shall be required for the introduction of any

new resolution or business not filed in proper form with the executive vice president's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Board of Directors or any member thereof, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

Sec 10. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board of Directors without discussion.

Chapter III
Annual election

Section 1. The House of Delegates, at its first session of the annual meeting, shall elect a Committee on Nominations consisting of one (1) delegate for each district, except that in any district having five hundred (500) or more regular and special members, there shall be elected one (1) additional delegate for each additional five hundred (500) members or majority fraction thereof. One (1) delegate representing the specialty sections shall also be appointed. Nominating committee members shall be limited to six (6) consecutive terms. Those committee members who have served six (6) consecutive terms upon adjournment of the final session of the 1994 House of Delegates annual meeting and following years shall have met this requirement. This committee shall become operative at the close of the final session of that annual meeting and shall function until the close of the final session of the following year's Annual Meeting. The incoming committee shall meet with the existent committee but without vote during the overlapping days of the annual meeting. Any vacancy occurring in the Committee on Nominations between the date of its formation and the time of its reporting shall be filled by appointment by the director or directors of the district in which the vacancy occurs, or if a nominating committee member is unable to attend a nominating committee meeting or is a candidate for an office a substitute for that member shall be named by the most senior director available from the affected district by written notification to the executive vice president prior to the meeting of the nominating committee, provided that if the vacancy or need for substitution occurs in the representation from the specialty sections, such vacancy or substitution shall be filled by ballot from among the section delegates. The Committee on Nominations shall convene at least two (2) months prior to the annual meeting of the House of Delegates to prepare a slate of candidates. This meeting, to be held at a time, date and location published to the general membership at least two (2) months before this meeting, shall include an open session of not less than one (1) hour to allow individual nomination of candidates. The Committee shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the name of the Board nominee for treasurer and the names of one or more members for each of the other positions to be filled.

Sec 2. The report of the Committee on Nominations and elections shall be the first order of business of the House of Delegates at the third session of the annual meeting.

Sec 3. The House of Delegates shall elect the president-elect, the treasurer, the speaker and vice speaker of the House of Delegates, and the delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the votes cast shall be necessary to elect. If no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie, and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the votes cast.

Sec 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Chapter IV
Duties of officers

Section 1. The president is the chief constitutional officer of the Society. Within the limits of the Constitution, Bylaws, and policies of the House of Delegates and Board of Directors, the president shall have the following responsibilities and commensurate authority:

a. deliver an annual address to the House;
b. serve as a member with right to vote on the Board;
c. preside at meetings of the Executive Committee of the Board;
d. participate, ex officio and without the right to vote, in sessions of the House;
e. initiate and propose policies and programs that will further the goals and objectives of the Society for consideration by the House, Board, commissions and committees;
f. support and articulate policies and programs adopted by the Board and the House.
g. promote physician interest and active participation in the Society.

Sec 2. The president-elect shall act for the presi-

dent in his absence or disability. If the office of president should become vacant, the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect, the Board shall appoint one of its members as acting president until the next meeting of the House of Delegates.

Sec 3. The treasurer shall be responsible to the Board of Directors, and shall advise and assist it in making decisions on investment policy and financial matters. The duties of the treasurer shall include the following:

a. Be responsible for all funds due the Society, together with bequests and donations;
b. Pay money out of the treasury only on written order of the secretary;
c. Subject the treasurer's accounts to such examination as the House of Delegates may order;
d. Annually report on the financial standing of the Society, including a balance sheet and income and expense report;
e. Give bond in such amount as the Board may provide.
f. Serves as chair of the Finance Committee of the Board.

Sec 4. The executive vice president is the chief executive officer of the Society charged with the execution of policy as created and defined by the House of Delegates and the Board of Directors. The executive vice president shall serve as an ex officio, nonvoting member of the Board; be responsible to the Board and serve as its secretary; assist the Board and officers in making decisions and implementing actions; share convictions and argue their merits; perform the functions ordinarily assigned to the office of executive vice president, and make an annual report to the House of Delegates. "As chief executive officer the executive vice president shall, within the limits of the Constitution and Bylaws and Board operating policies, effectively perform the general managerial function for the Society and all of its divisions, activities, and personnel including employment and, as necessary, termination of all employees; be responsible for and have the necessary authority to direct, supervise, and coordinate all programs, projects and major activities of the Society and all wholly owned subsidiaries; formulate and recommend for approval of the Board basic policies and programs which will seek to achieve the objectives and goals of the Society; fully inform the Board on the condition and operation of the association; cooperate with the Board and Treasurer in establishing a program of fiscal responsibility for the Society including development, recommendation and upon approval, operation within an annual budget; act to insure that all funds, physical assets, and other property of the Society are appropriately safeguarded and administered; develop and maintain effective internal and external communications with the membership and other organizations and agencies, both public and private, so as to enhance the positions of the Society and the objectives of its membership; and through effective management and leadership, achieve economic, productive performance, forward-looking programming, and constructive growth of the Society."

Note: Following adoption of this Bylaw change (Sec. 4 above) in 1987, the Board agreed to develop and maintain a set of current "operating policies" between itself and the secretary to detail the more specific duties and expectations important to a good working relationship between the Board and the secretary.

Chapter V
Board of Directors

Section 1. The Board of Directors shall be the executive body of the Society. Between meetings of the House of Delegates it shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

Sec 2. The Board shall meet during the annual meeting and at such other times as necessity may require, subject to the call of the chairman or on petition of three directors. It shall hold an annual meeting for purposes of organization and other business.

Sec 3. The Board shall elect a chairman and a vice chairman from among its voting members. It may create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities. Its chairman shall submit an annual report to the House of Delegates including all major actions and policy decisions of the preceding year.

Sec 4. Each director shall be the organizer and mediator for the district. Directors shall visit each county in their district as needed for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep informed of the activities of the component societies in the district. Each director shall arrange for an annual conference or caucus with the societies or their delegates within the district, at which time information shall be disseminated concerning the activities of the State Medical Society and component societies within the district. Each director shall report as necessary to the Board. The necessary traveling expenses incurred by each director in the line of duties herein imposed may be allowed on a proper

itemized statement, but this shall not be construed to include the expense of attending the annual meeting of the Society.

Sec 5. The Board of Directors shall be the judicial body of the Society. It may decide any questions of conduct or discipline of members, or any questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. It shall develop and publish procedures for discipline, including denial of initial or continuing membership, for those physicians who fail to provide quality health care, failure to pay dues, loss of license to practice, or other cause. Its decisions in all cases shall be final, including the right to expel a member should a component society fail to do so after being so requested by the Board. The Board's right to original jurisdiction includes but is not limited to the right to decide cases when:

a. the affected parties reside within the boundaries of a single county medical society and that society does not wish to assume jurisdiction;
b. the affected parties reside in two or more component medical society jurisdictions. The Board also has within its authority the right to appoint a commission or commissions to which any or all such matters may be referred for investigation, evaluation and decision to acquit, admonish, or otherwise discipline as appropriate. A member may appeal to the Board the decision of such commission or the action of a county society as provided in Chapter X, Section 3. If the recommendation is for suspension or expulsion of a physician from Society membership, final action must be taken by the Board.

Sec 6. Charters shall be issued to county societies only on approval of the Board, with ratification by the House of Delegates, and shall be signed by the president and executive vice president of this Society. Upon the recommendation of the Board, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Sec 7. In sparsely settled sections, the Board shall have authority to organize the physicians of two or more counties into societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec 8. The Board shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have the authority to appoint an editor of the Journal and such assistants as it deems necessary.

Sec 9. The Board shall select a qualified independent accounting firm and receive an annual audit of all accounts of this Society. With the treasurer, it shall supervise the investment of funds. The Board shall adopt an annual budget providing for the necessary expenses of the Society.

Sec 10. The Board may, by interim appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates. The appointee shall serve until a successor has been elected and has qualified. When a district initially qualified for an additional director, such position shall be considered new and not a vacancy to which the Board is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article VI of the Constitution. The initial term shall be so established as to maintain the election of substantially one-third of the directors each year.

Sec 11. The Board may elect as executive vice president one who need not be a physician or a member of the Society.

Sec 12. The Board shall provide such facilities for the Society as may be required to properly conduct its business.

Sec 13. The Board shall nominate a director to serve as treasurer and shall report the nominee to the Committee on Nominations in the manner provided by Chapter III of the bylaws.

Sec 14. There shall be an Executive Committee of the Board which shall consist of the president, the president-elect, the immediate past president, the chair and vice chair of the Board, the chair of the Finance Committee, the speaker, and two additional district directors to be appointed annually by the chair of the Board. The Alliance president and president-elect shall be ex-officio non-voting members. The Executive Committee shall possess and may exercise all the powers of the Board of Directors between meetings of the Board. The Executive Committee shall meet prior to the meetings of the Board and at such other times as may be required, subject to the call of the chair or on petition of three voting members, and shall report all actions taken by it to the next meeting of the Board, for its consideration.

Chapter VI
Commissions and committees

Section 1. The Board shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary to properly conduct the affairs of the Society. Membership on such committees and commissions shall be limited to members of the Society and its Alliance. Nonmembers of the Society

or its Alliance may be appointed as special representatives should their expertise and knowledge be of benefit to the goals of such commissions or committees. Such individuals shall not have the right to vote or hold office. Each commission and committee shall have the duty of being informed on matters within the area of its special interest. They shall represent the Society's interests by continual contacts with voluntary and governmental agencies having related concerns with the intention of coordinating efforts to serve the health interests of the people of Wisconsin. They shall develop recommendations from their studies and activities for action by the Board or House of Delegates.

Sec 2. Specialty sections shall be regarded as special committees of the Society from which the Board or any commission or committee may seek advice and assistance on matters of special or general concern to the profession and the health of the people of Wisconsin. The specialty sections will be expected to give special requests prompt consideration and response so as to enable the Society to make maximum use of their resources.

Chapter VII
Dues and assessments

Section 1. The annual dues and assessments of this Society shall be determined by the House of Delegates and shall be levied per capita on the members. Dues and assessments shall be payable as determined by the Board of Directors. Any member whose current year's dues have not been received by the executive vice president on or before the dues payment deadline, as established by the Board of Directors, shall be deemed in arrears and shall be removed from the membership rolls of the county society and this Society until such time as full dues for the current year have been received.

Sec 2. The record of payment of dues and assessments on file in the offices of this Society shall be final as to the fact of payment by a member and to the right to participate in the business and proceedings of the Society or the House of Delegates and to any other benefits and privileges of membership.

Chapter VIII

The Board of Directors shall adopt ethical guidelines for the members of this Society.

Comment: On July 18, 1981 the Board of Directors adopted the Principles of Medical Ethics of the AMA as the ethical guidelines of the Society.

Chapter IX

The current edition of Sturgis Standard Code of Parliamentary Procedure governs this organization in all parliamentary situations that are not provided for in the law or in its charter, constitution, bylaws, or adopted rules.

Chapter X
County societies

Section 1. All present county societies or those that may hereafter be organized in this state shall, upon application to the Board of Directors, receive charters from this Society, provided that their constitutions and bylaws have been submitted to the Board and found in conformity with the Constitution and Bylaws of the State Medical Society. All revisions shall be submitted to the Society, approved by the Board, and filed with the executive vice president. Where a county society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Board, shall be deemed to apply.

Sec 2. Only one component medical society shall be chartered in each county.

Sec 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Board of Directors of the State Society. Its decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Board of the State Society for final determination. The mechanisms and procedures which apply to the appeal process shall be those adopted by the Board.

Sec 4. Each component county society shall elect one or more delegates and may elect an equal number of alternates to substitute for any absent delegates from that component society, for a term of two calendar years, to represent it in the House of Delegates of this Society, in accordance with Chapter II, Section 1, of these Bylaws. The term of office shall begin on January 1 of the year succeeding the election of such delegates and alternates.

Sec 5. The secretary of each county society shall keep a roster of its members.

Chapter XI
Specialty sections

Section 1. The House of Delegates shall establish specialty and special sections within the Society. It shall have the power to combine, enlarge, or discontinue any or all of such sections so established using the following guidelines:

a. For specialty section to be designated it must represent a specialty which is represented in the American Medical Association House of Delegates and

b. Have at least twenty (20) members of the specialty who are members of this Society.
c. If no representative from the specialty section registers as a representative of that section for three (3) consecutive annual meetings, the specialty section will be dropped with the option of reapplying after one year, provided the above criteria are met.
d. From time to time special sections not meeting the above criteria may be established by the House of Delegates.

Sec 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest. Qualifications for membership in any section shall be established by the members of such section, subject to approval of the Board of Directors, Scientific meetings of a section shall be open to all members in good standing of the State Medical Society.

Sec 3. The officers of each section shall be elected by and from its membership. The terms of such officers shall be for one year, but any officer may be reelected.

Sec 4. No section shall have the power to bind the State Medical Society by any resolution or other action. No such resolution or action shall be publicized unless it shall first have been approved by the House of Delegates, or by a majority of the Board when the House is not in session. No resolution adopted by any section shall be effective until likewise so approved.

Sec 5. Each section shall elect a delegate and an alternate to the House of Delegates. The term shall be for two calendar years without limitation on number of terms.

Sec 6. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VI of these Bylaws.

Chapter XII
Amendments

These Bylaws may be amended at any annual meeting by a majority vote of the delegates present, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one session of that annual meeting.

American Medical Association Principles of Medical Ethics

PREAMBLE: The Medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues and of other health professionals, and shall safeguard patient confidences, within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

WHAT YOU DON'T KNOW CAN HURT YOU.

That's why Congress *must* pass the Patient Protection Act.

There are things insurance companies don't want you to know about their health plans. That's why you need the facts. So you can make informed choices and get quality care in spite of their efforts to keep you in the dark.

The Patient Protection Act will require insurance companies to give you all the information you need *before* you join a health plan. They'll have to tell you what is and isn't covered in their plan. What sort of incentives they give to limit the care you get. What sort of approval process you have to go through to get the care you need. And how many people have dropped out of their plan because they were dissatisfied with the care they got.

It will also make sure your doctor has a say in your plan's medical policies and make it illegal for your plan to fire your doctor for giving you all the care you need. What's more, it will allow you to choose your *own* doctor – instead of having one chosen for you.

In short, the Patient Protection Act requires insurance companies to give you a full explanation of how their plan's limitations affect you. So you and your family can make an informed, intelligent decision about the one thing that's more important than any other. Your health.

This is the moment of truth. Call your senators and representative now. Demand that they support the Patient Protection Act. Because when you're dealing with the insurance industry, what you don't know really can hurt you.

American Medical Association

Physicians dedicated to the health of America

1994 House actions on resolutions and reports

Resolution 1 directs the medical society to draft, and advocate for passage, the American Academy of Pediatrics model bill: "Protection of Children from Handguns Act." **Action:** referred to SMS Board of Directors.

Resolution 2 calls for the SMS to petition the Wisconsin Legislature to convene a legislative council study on violence in Wisconsin. **Action:** adopted.

Resolution 3 urges the medical society to inform the public of how malpractice costs increase health care costs. **Action:** substitute resolution adopted.

Resolution 4 gives SMS support to the position that only malpractice settlements by insurance carriers in excess of $30,000 be required to be reported to the National Practitioner Data Bank and state licensing boards and bring this position to the attention of lawmakers. **Action:** adopted.

Resolution 5 urges the medical society to oppose the development of practice guidelines by government and support current SMS efforts relating to practice-based clinical outcomes research. **Action:** substitute resolution adopted.

Resolution 6 calls for support of legislation making participation in the Patients' Compensation Fund voluntary and allow insurance agencies to once again sell $1 million liability policies. **Action:** substitute adopted.

Resolution 7 gives SMS support to the AMA position, approved at the June 1993 AMA meeting, permitting use of an alternative data bank by state medical examining boards. **Action:** substitute resolution adopted.

Resolution 8 calls for the SMS to oppose the use of moratoria of undetermined length by the Cost Containment Commission to defer conducting reviews and determinations requiring action by the commission under the provisions of Chapter 250.

Continued on next page

Pauline Jackson, MD, passes the SMS presidential medallion to Richard Roberts, MD, JD, at the 1994 annual meeting.

Continued from preceding page
Action: substitute resolution adopted.

Resolution 9 calls for the SMS to support legislation providing mandatory, prompt and binding arbitration in medical malpractice cases and establishing an arbitration panel. **Action:** substitute adopted.

Resolution 10 requires the SMS to encourage the Legislature to establish a program to take the onus of eligibility off the physician's office when determining a patient's eligibility for the indigent drug program. **Action:** rejected.

Resolution 11 pertains to a proposal to facilitate admission of patients to extended care facilities and calls for a copy and explanation of 1993 Wisconsin Act 187 in the *Wisconsin Medical Journal*. **Action:** substitute resolution adopted.

Resolution 12 calls for the SMS to include in its program on domestic violence information on the appropriate discipline of children. **Action:** substitute resolution adopted.

Resolution 13 calls for the SMS to oppose any effort to increase the registration fees for vital records over and above administration costs. **Action:** rejected.

Resolution 14 requires all fiscal notes in excess of "current budgets" be reviewed and approved by the SMS treasurer and speaker of the House before they are published in the delegates annual meeting handbook. **Action:** amended.

Resolution 15 encourages SMS members to support the Health Education Center of Wisconsin through publicity efforts and liaisons with organizations representing the targeted audience as local county societies deem appropriate. **Action:** adopted.

Resolution 16 calls for the SMS to replace the current medical student section with two special sections, one for Medical College of Wisconsin students and one for University of Wisconsin Medical School students. **Action:** substitute resolution adopted.

Resolution 17 calls for the establishment of a group practice section formed by medical group presidents who are physicians or their physician designees. **Action:** amended.

Resolution 18 urges the SMS to develop model hospital medical staff bylaws to use as a guideline for the benefit of its members. **Action:** adopted.

Resolution 19 calls for the SMS to work with the Bureau of Quality Compliance to reexamine the administrative decision that antidepressants are viewed as chemical restraints. **Action:** amended.

Resolution 20 directs the SMS to work with the Department of Health and Social Services to reexamine and remove the diagnosis of depression as a trigger to automatically require level I and II screening in the annual review of nursing home residents. **Action:** amended.

Resolution 21 calls for the SMS to formally request that the Office of the Commissioner of Insurance include the SMS in all future "strategy" documents that have an impact on practicing physicians and establish the means to define practice guidelines for high risk issues in each specialty. **Action:** substitute adopted.

Resolution 22 seeks a review of policy calling for universal vaccination of children against hepatitis B. **Action:** rejected.

Resolution 23 directs the SMS to develop guidelines as to the proper scope of practice for physician assistants and nurse practitioners and promulgate its findings, and refer the issue to the AMA for development of national standards. **Action:** substitute resolution adopted.

Resolution 24 calls for SMS to develop liaisons with entities involved in primary care education and prepare an annual report summarizing current programs. **Action:** referred to Board of Directors.

Resolution 25 promotes the participation of SMS members in state and local childhood immunization initiatives. **Action:** adopted.

Resolution 26 seeks legislation that would require peer review organizations to be registered and licensed through the Office of the Commissioner of Insurance. **Action:** rejected.

Resolution 27 pertains to case management of AIDS with hospital pre-admission screening. **Action:** substitute resolution referred to Board of Directors.

Resolution 28 directs SMS staff to work to repeal the prohibition against reducing or eliminating copayments and deductibles. **Action:** amended.

Resolution 29 states that phase 1, 2, and 3 cancer research protocols should be a covered benefit in the State of Wisconsin employees benefit plan. **Action:** referred to Board of Directors.

Resolution 30 directs SMS staff to study and make a recommendation regarding repeal of the current exemptions of the "willing provider law" enacted in Wisconsin. **Action:** substitute resolution referred to Board of Directors.

Resolution 31 directs the SMS to seek legislation in the spirit of health care cost containment that would

exempt physicians from the collection of Medicaid coinsurance amounts if the cost of the collection effort exceeds the amount to be collected. **Action:** adopted.

Resolution 32 urges efforts to publicize the message that current Medicaid and Medicare payments to physicians for house calls do not encourage house calls and do not promote cost effective care. **Action:** substitute resolution adopted.

Resolution 33 reaffirms the SMS position that physician reimbursement for the same service not vary based on specialty. **Action:** substitute resolution adopted.

Resolution 34 seeks correction of Medicare reimbursement inequities to assistant surgeons. **Action:** substitute resolution adopted.

Resolution 35 calls for the SMS to take appropriate legal action against Medicare and seek legislation to ensure prompt appeals. **Action:** rejected.

Resolution 36 requests the SMS to take legal action against Medicare to ensure that when downcoding is performed by Medicare a prompt and immediate appeals process be available to the physician and his or her patient. **Action:** rejected.

Resolution 37 pertains to legal action and legislative initiatives to ensure rural physicians are compensated at the same level as urban physicians. **Action:**rejected.

Resolution 38 seeks specific legal action pertaining to non-payment of rural physicians' usual and customary professional fees. **Action:** rejected.

Resolution 39 also seeks specific legal action pertaining to non-payment of rural physicians' usual and customary fees. **Action:** rejected.

Resolution 40 urges legal action against Medicare to ensure that reimbursement for rural hospitals be elevated to the levels of urban hospitals. **Action:**rejected.

Resolution 41 urges reorganization of the SMS as a professional physician guild for purposes of negotiation and representation. **Action:** rejected.

Resolution 42 calls for the SMS to identify efforts to oversell medical services to the public and call attention to the increased costs resulting from overselling. **Action:** rejected.

Resolution 43 directs the SMS to advocate for extension of medical care services to the state's urban and rural under-served areas by working closely with those organizations committed to developing proposals to correct the problems of accessibility to medical care in Wisconsin and by ensuring that minority physicians serving populations in under-served areas participate in those activities. **Action:** substitute resolution adopted.

Resolution 44 directs the SMS to take immediate action with the state and relevant federal agencies to identify and eliminate disruptions created in continuous prenatal care by uncoordinated government programs so pregnant women are able to maintain a continuous relationship with a single physician throughout pregnancy. **Action:** adopted.

Resolution 45 urges the AMA to include the following in health system reform to better address the needs of children: an adequate pe-

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George Rhodes (l) receives one of the 1994 Houghton Awards from CESF President Stephen Webster, MD, (r).

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riodicity schedule similar to the one included in the HCFA-developed "Bright Futures Project"; hearing aids; tort reforms including a $250,000 cap on non-economic damages, a statute of limitations of 6 plus 2 years and a limitation of plaintiff lawyer fees through the use of a sliding scale; and standards of eligibility for long-term care of children based on limitations of activities. **Action:** substitute resolution adopted.

Resolution 46 calls for organized medicine to oppose the creation of a National Health Board as defined in the Health Security Act and for SMS delegates to submit this resolution to the AMA for consideration. **Action:** amended substitute resolution adopted.

Resolution 47 opposes the Health Security Act of 1993 proposal of an all-payor health care fraud and abuse enforcement program as it specifically applies to the seizure of property; support efforts to clearly define health care fraud and establish an intergovernmental commission to investigate fraud and abuse; pursue enactment of laws that ensure equal application of due process rights to physicians in health care fraud prosecution; and submit a resolution on this subject to the AMA. **Action:** substitute resolution adopted.

Resolution 48 calls for the SMS to oppose the Health Security Act of 1993 proposal of an all-payor health care fraud and abuse system. **Action:** amended substitute resolution adopted.

Resolution 49 opposes any arbitrary, inequitable or discriminatory application of plan benefits or medical care under any state or national health care plan and specifically opposes discriminatory allocation of medical care on the basis of class, means, age or gender. **Action:** substitute resolution adopted.

Resolution 50 urges the SMS to oppose restrictions on fee-for-service in any plan introduced to change the health care system and create a written advisory for use by physicians in creating fee-for-service plans. **Action:** referred to Board of Directors.

Resolution 51 calls for the SMS to oppose efforts to impose quotas in training programs forcing practice and specialty selection. **Action:** adopted.

Resolution 52 requests that the SMS develop and promulgate a definition of primary care and primary care physicians, based on training and experience so that uniformity can be developed as discussions regarding access and availability of primary care occur. **Action:** filed.

Resolution 53 asks the SMS to promote inclusion of medical IRAs as part of a comprehensive health system reform initiative as a way for patients to establish a tax-deferred account to which employers and patients can directly deposit money to pay for health care costs such as deductibles, co-payments and drugs. **Action:** substitute resolution adopted.

Resolution 54 asks the SMS to designate obstetricians and gynecologists as primary care providers for women and include that definition in *Wisconsin Care*. **Action:** filed.

Resolution 55 requests that the SMS continue to support health care reform that includes: universal access for all Wisconsin citizens; continuity of care and patient choice of physician; basic benefits for all patients; support for continued quality medical services; and reform that deals effectively with factors mitigating against efficient health care delivery including malpractice reforms, undersupply of primary care physicians, inadequate reimbursement, and simplication of paperwork and plan administration. **Action:** filed.

Resolution 56 seeks SMS support of tax deductible medical savings accounts as an option for all Americans and urges opposition of any reform plan that would force patients to participate in managed care, HMOs or government medical care. **Action:** substitute resolution adopted.

Resolution 57 asks for the SMS to recommend enactment of a tax code that will treat the health care expenses of all workers in the same manner, and if any special favors are to be granted by the tax code to anyone then such special exemptions should only be granted to those who are buying true insurance with the payment of actuarily sound premiums for unexpected, unusual, or catastrophic illnesses and expenses. **Action:** rejected.

Resolution 58 calls for the SMS to support the goal of removal of PCB-contaminated sediments. **Action:** referred to Board of Directors.

Report A of the Board of Directors recommends that 1993 Resolution 8 regarding liability for Medical Assistance obstetric care not be adopted; calls for submission of a recommendation on 1993 Resolution 38 mandatory arbitration in medical malpractice cases to the 1995 House of Delegates; continues anti-tobacco campaign to oppose tobacco use in nursing homes and protect workers from tobacco smoke in the work place; and adopts a policy on crime injury reporting and domestic violence. **Action:** adopted.

Report B of the Board of Directors includes the 1994 budget; a recommendation for a $10 dues recommendation; proposes a constitu-

tional amendment removing a cap on Board of Directors size; approves a plan to separate the scientific portion from the SMS annual meeting; and provides an update on the MinnesotaCare tax on non-resident physicians. **Action:** section on budget and MinnesotaCare tax filed; dues recommendation and annual meeting change adopted.

Report C of the Board of Directors recommends SMS support for driver blood alcohol testing in fatal crashes; opposes legislation on physician-assisted suicide; adopts policies on euthanasia and withdrawal and withholding of treatment; recommends the SMS develop a medical quality research foundation with CESF for the purpose of developing, funding and implementing medical quality outcomes research in Wisconsin; authorizes the SMS to cosponsor a managed care credentialing demonstration project in Wisconsin; provides guidelines for terminal care; gives continued endorsement to a document on practice parameters; adopts a policy concerning hospital discharge criteria; concurs with an SMS Commission that installation of school bus seat belts not be adopted; and approves an interprofessional code on dispute resolution. **Action:** adopted.

Report D rejects House of Delegates Resolution 19 on a survey for the establishment of a Medicare single payment area and concurs with an SMS commission that no action be taken on 1993 House of Delegates Resolution 35--nonpayment of rural physicians' usual and customary professional fees based on inappropriate out-of-state reviewers; and 1993 House of Delegates Resolution 36 on nonpayment of rural physicians usual and customary professional fees. **Action: adopted.**

Report E discusses health system reform; 1993 House of Delegates resolutions 33 and 45--Adequate Public Funding for Predoctoral and Graduate Medical Education; and 1993 House of Delegates Resolution 44 on long term care. **Action: adopted.**

Report F of the Board of Directors deal with expansion of Medicaid drug prior authorization and supports the exemption of certain drugs. **Action: adopted.**

Report G discusses future health system reform activities for the SMS and reiterates strength for the eight essential elements of *Wisconsin Care* while noting policy must continue to be clarified and strengthened. **Action: adopted.**❖

House of Delegates Nominating Committee: 1994-1995

District 1
Lucille B. Glicklich, MD, 2000 W Kilbourn Ave, Milwaukee 53233
William J. Listwan, MD, 205 Valley Ave, West Bend 53095
Timothy G. McAvoy, MD, 1751 East Main, Waukesha 53186
Thomas A. Reminga, MD, 330 E Kilbourn Ave, Ste 730, Milwaukee 53202
John E. Ridley, III, MD, 2315 N Lake Dr, Ste 1001, Milwaukee 53211
Gregory A. Shove, MD, 3807 Spring St, PO Box 085001, Racine 53408-5001
Frank H. Urban, MD, 3645 Emberwood Dr, Brookfield 53005

District 2
Adam H. Balin, MD, 753 N Main St, Oregon 53575
Jerry M. Ingalls, MD, 1515 Tenth St, Monroe 53566
Paul A. Wertsch, MD, 4221 Venetian Ln, Madison 53704

District 3
Mark H. Andrew, MD, 125 W Jefferson, Viroqua 54665

District 4
Robert E. Phillips, MD, 1000 N Oak Ave, Marshfield 54449

District 5
David R. Weber, MD, 80 Sheboygan St, Fond du Lac 54935

District 6
Joseph C. DiRaimondo, MD, 1636 Miriam Rd, Manitowoc 54220, chair

District 7
Philip J. Happe, MD, PO Box 1510, Eau Claire 54702-1510, secretary

District 8
Joseph M. Jauquet, MD, 1625 Maple Ln, Ashland 54806-3610

Specialty sections
Richard S. Kane, MD, 945 N 12th St, PO Box 17932, Milwaukee 53217❖

Presidential address
A great flame follows a little spark

THIS PAST YEAR as SMS president has been a rewarding time for me, with truly never a dull moment. My one regret is that the parameters of distance and getting enough sleep set irreducible limits on what I would like to have done.

Attending county medical society meetings was both an enjoyable experience and probably the best way to understand our most active members' concerns and ideas. The field staff is particularly helpful and does an excellent job of liaison between madison and all of the rest of us out there.

I also appreciated the many telephone calls and letters I received from physicians who took the time to express their opinions about how the medical society can be most helpful to them and to their patients.

Pauline M. Jackson, MD

Wisconsin physicians and our organization enjoy an outstanding reputation among our colleagues elsewhere. Three quarters of the American public may not know where Wisconsin is because the national weather reports generally skip right over us, but other physicians do know--as I learned during the AMA functions I attended. It is a good feeling to be part of such an exceptional family.

I have down-played my status as the first woman president of the SMS because I believe such distinctions are no longer necessary. It is gratifying to see increasing numbers of women at county medical society meetings who are taking leadership roles. Perhaps, however, we women should posthumously thank the members of the Wisconsin State Medical Society of 1872 who first opened membership to women with this questionably encouraging remark. This is a quote: "St Paul may have ruled her out of the pulpit, but St Paul never did say that she would not make a good Samaritan."

Well,t hat may not have sounded welcoming enough to the women of the time, and it was another 13 years before the first woman physician actually joined the State Medical Society. One hundred and twenty-two years later, here we are.

I want to thank my fellow physicians for giving me this responsibility and the SMS staff for their superb assistance.

My efforts to help publicize the problem of tobacco addition by young people brought a diverse array of reactions, as expected, from thoughtful recognition to times when I felt it best to leave by the nearest exit. In keeping with that experience, I shall close with an admonition from Dante's *Divine Comedy*, which supports our continued motivation to improve the health of Wisconsin citizens.

In this passage, Dante is expressing his idealistic views of mankind and denouncing what he believes to be corruptions. He is visited by an ancestor who arms him that this degree of outspokenness will keep him in exile and make him dependent on a patron. Nonetheless, he goes ahead to say: "Avoiding every lie, make your entire vision manifest. And where it itches, let the people scratch. You will experience the salty taste of someone else's bread and know how hard to climb up and down by someone else's stair."

Thank you.❖

Address of the president elect

Children, gun violence and the healing community: Wisconsin physicians together making the difference

SPRINGTIME IN Wisconsin means storm clouds and rain showers--sometimes hour after hour. Tonight, however, I want to describe to you storm clouds of a different kind. I see new storm clouds gathered over Wisconsin. From our Lake Michigan beaches in the east to our Mississippi bluffs; from our pine woods in the north to the rolling pastures in the south. The growing maelstrom is gun violence and children. Like cracks of lightning, gun shots explode the lives of our young people and flood their families in a torrent of tears.

Mushrooming thunderheads and lighting bolts of gunpowder threaten our future: either by striking our children dead or by robbing them of the security of a safe childhood.

Richard G. Roberts, MD, JD

From the back roads of Wisconsin to the mean streets of Washington D.C. to the boulevards of California, I've learned to read the weather and tonight I'd like to share with you the lessons I've learned.

The first lesson occurs in January 1980; it's a clear, frigid night in metropolitan Washington D.C. Four months from my medical school graduation, my wife Laura and I dance with joy watching the exploits of the United States hockey team at the 13th Winter Olympiad in Lake Placid, NY. Just the two of us, celebrating in front of the television in our third floor apartment. In the midst of our celebration we hear a distant sound, like someone kicking the firedoors that lead to each apartment. Who could be so rude to disrupt our Olympics?

Screams from below freeze us, for a moment. We race down two flights of stairs to find a 24-year old man, our neighbor, slumped back against his door. He is in the throes of dying, with three 45 caliber gun shot wounds to his chest. He smells of blood and vomit, and sounds of death.

Laura, a teacher, has just been certified in CPR--she figures it will help if a student is struck by lightning. But this is more than "Andy, Andy are you all right?" What has happened to our night? This is for me, too far removed from the comforting camaraderie of the hospital. This is for me, too close to home.

We start CPR with a practiced efficiency that deceptively suggests it's just another weeknight at home for the Roberts family. We are relieved to see the paramedics arrive within a few minutes. But our relief turns to astonishment when they refuse to enter the glass doors to the building without police escort.

"It's, after all, a dangerous situation;" they shout through the glass, "Regulations require us to wait."

The minutes drag on--compression, breath, a glance up at the faces in the glass. Where are the cops? Where is the killer? Repeat the cycle: compression, breath. More red lights and sirens. Finally.

I learned the lesson on vulnerability: You can't afford to ignore the weather when you hear the thunder roll. "You don't need a weatherman to know which way the wind blows."

The next lesson. February 1983. It's a crisp Monday night in a Los Angeles emergency room. Monday nights are good duty for a moonlighting resident. The weekend crazies have gone back to their jobs; I will probably get in some reading and sleeping.

But this Monday night is different. This Monday night a member of one gang has crossed the turf of another. Offense is taken. Gunfire results.

At a distance, gang members are notoriously bad shots. Perhaps they

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don't take enough target practice. On this Monday night, a badly aimed bullet crosses the street, shatters a window and blasts through the body of a fourteen year old girl doing her homework. She is several weeks shy of her *quince*, her 15h birthday--a major event of the life of a young latina.

On this Monday night the ambulance delivers to my emergency room the body of a dead teenager. In hot pursuit are a dozen raging relatives, expecting medical miracles. But there are no medical miracles on this Monday night. It falls to me to inform the worried and suspecting family. The waiting room is packed with angry young men wearing tattoos and waving Uzi machine guns. I've never before seen an Uzi; at least not so close to my nose. It looks like a toy, but this doesn't feel like a game.

The family's English is poor; my Spanish is worse. *"Lo siento mucho. Puedo ayudar?"* Into the awkward breach, steps the head nurse, a small woman from Guatemala. When I say small, even I tower over her. She glides up to the gang leader, the biggest person in the room flashing the biggest gun. She whispers some soothing Spanish. She speaks so softly that everyone has to lean in to hear. The room is comically transformed into a football huddle, mean guys with big guns leaning in to listen to little coach.

They all leave a few minutes later, satisfied that nothing more could have been done. I learned the lesson of leadership: A gentle hand and a helping heart can evaporate the storm clouds.

That Monday night in the Los Angeles emergency room taught me another lesson. I had experienced personal danger and had feared for my own safety before, that was a familiar emotion. But now I had an 8-month-old son, Matt, toddling around at home and I realized for the first time that if I did something macho or stupid, he might be left without a dad. I was responsible for a future. I learned the lesson of a greater power: We are all affected by the weather.

After residency, Laura and I eagerly returned to the family and refuge of our native Wisconsin. Leaving the sunshine of southern California was hard, leaving the menacing tempest of violence was easy. Of course, we were smart enough to move back to temperate southern Wisconsin. The best part of our years back in Wisconsin has been family. Family has made my journey possible. More importantly, family has made my journey worth the effort.

The stories I share with you are intensely personal. They are my eyewitness accounts of how gun violence wounded my life when it wasted the lives of people who were too young to die. I have other lessons I could share; I expect that you do too. My stories are a bit unusual in that the killer and victim did not know each other. The cold truth is that about half of firearm deaths are suicides. Of the remaining half that are homicides, half of those are committed by a family member or friend.

Firearm violence has become a major public health problem. Gunshot injuries are now the second leading cause of death for children and young adults aged 10 to 34 years. In several states, the overall number of deaths due to firearms now exceeds the number of deaths due to auto accidents. A black man in America must survive into his 40s before something other than gun violence becomes his most likely reason for dying. If you think this affects only inner cities, you're wrong. If you think this doesn't affect you, than think again. Think about which way you're going to turn when you step outside the hotel this evening. Right or left. It may make a difference.

If you think this is about slamming the National Rifle Association, then think again. I have a number of relatives who are avid hunters. I admire their dedication to firearm safety. They appreciate that guns are serious business.

No, this is about a 4-year-old playing with a loaded rifle--Bang! Bang! You're dead! You *are* dead! What's dead? No, this is about a depressed 15-year-old grabbing a .38 because there seems to be no alternatives. No this is about a 19-year-old protecting turf by pulling out a Raven. Edgar Allen Poe reminds us of what the raven said.

Thinking about a problem like gun violence and kids can seem overwhelming. How can we get our arms around it? What can we do? Albert Camus wrote, "The most difficult task of all, is to reconsider everything from the ground up, so as to shape a living society inside a dying society." We need to reconsider everything from the ground up. We need to rebuild a living society.

As physicians, this thought terrifies us. Our daily experience is plagued with uncertainty, fraught with doubt. We live in a world of life and death decisions that depend on an inexact science with incomplete information and, yes, all the while we are shadowed by malpractice lawyers. We seek certainty through the controlled environments we are able to shape in the hospital and the clinic. We grow wearied--or worse, hardened--by the suffering we witness each and every day. We incrementally slip into cynicism. We privately drift into despair.

The storm clouds that now gather over Wisconsin, gather over Wisconsin's physicians, too. How can we possibly reach out to assist our communities with the problem of gun violence and children when our energies seem consumed with individual patient and family needs, our attention distracted by the chaotic swirl called health system reform? How can we help society get its act

together, when medicine can't seem to get its act together? We have our own gang wars: specialties and medical enterprises divided and fighting over turf. How can we rebuild a living society and weather the storm?

We can do it the same way we heal a patient. One child at a time; one community at a time. Offering each a place under the umbrella. We do it through leadership, professionalism, and unity.

We show our leadership by proving to our communities that we can end the killing of our kids, that we can stop the slaughter. We can achieve limited access to guns by children. Trigger locks, gun swaps and hunter safety programs can all help. Ask your adult *and* pediatric patients if there are guns at home. How secure are the weapons? How safe do they feel? Why should it be easier for a kid to get into a box of bullets than a bottle of Tylenol?

We show our professionalism by our willingness to step forward. Recall that in Hippocrates' time, being a professional meant that you professed, that you declared publicly that you were a healer and a helper of the sick. We will need to build on our ancient heritage by developing new skills and perspectives. New skills and perspectives require courage and practice. Aristotle noted that character and virtue are developed by practice. Of course, some of us need more practice than others.

We show our unity by working together on behalf of our communities through our medical society. This is our umbrella, our shield against the storm. New skills and perspectives are integral to the continued development of our medical society. We need the leadership of the growing number of women, minority, and international physicians who have so much to share but who have felt kept out or put out by participation in the Medical Society.

We do it through a series of small acts and grand gestures. Dr Stephen Hargarten is an emergency physician here in Milwaukee who decided to speak out against gun violence. He had committed himself to the removal of the Black Talon bullet which explodes into a barbed starburst which is designed to tumble and tear through human tissue, achieving maximum destruction. I should say was designed. It cost Dr Hargarten a 29-cent postage stamp to mail an exploded Black Talon casing to Sen Patrick Moynihan. Senator Moynihan was so affected that he proposed a 10,000% tax on Black Talon bullets. The public outcry over the bullet drove Winchester to halt its production.

We can blow away the clouds of gun violence for our kids. We can reach beyond self-interest to lead our communities. We can profess our commitment to serve our patients, families and communities. We can unite around an issue that joins us together: our future, our children.

Small acts and grand gestures. One child at a time. Make room under the umbrella. Side by side, Wisconsin's physicians and their communities together making the difference.

I've looked ahead and read tomorrow's weather report. I see that the cold, hard rain is going to let up. I see a morning full of fresh possibility. I see that it's going to be a fine day.❖

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American Heart Association

Special issue on violence

SMS President Richard Roberts, MD, JD, hopes to help physicians fight the rise of death and injury from gun violence in Wisconsin during his term. In coordination with the campaign, the *Wisconsin Medical Journal* is seeking articles from Wisconsin physicians on the subject of gun violvence, exploring its nature, causes, costs, effects, and possible solutions. The special issue is tentatively set for September.

There is room in the *WMJ* for approaching the issue from many angles: scientific, socioeconomic, and organizational articles, as well as letters of opinions and expression of personal experiences and feelings in "Soundings."

Guidelines for writers are available from the *WMJ*: 257-6781 (Madison area) or 800-362-9080.❖

EVP report to the House of Delegates
Crazy times demand crazy organizations

WELCOME TO THE nano-second '90s: These are wild and woolly times. How wild are they? Let me paraphrase for you some of the things management guru Tom Peters has been saying on the lecture circuit and in his syndicated newspaper column.

Item: The industrial age came to an end on an unsung day in January 1992. On that day, the total stock market value of the Microsoft Corporation surged past the total stock market value of the General Motors Corporation.

Item: In the new economy, of which health care is a large part, Madonna's trade balance is greater than Detroit's. Two thirds of Madonna's income is from overseas, while Detroit is still running a trade deficit of $30 billion to $40 billion a year.

Item: Today there are some 75 cable networks available nationwide, and by the end of the year the number of available channels may reach 500.

Item: On average a new grocery product is produced every half hour.

Item: The time it took from the Jonestown massacre to the first TV movie about it was 513 days; from the Waco tragedy to TV was just 34 days.

These are crazy times: A year or so ago, the presidents of General Motors, IBM, Westinghouse, Kodak and American Express were all fired within 180 days of each other.

Why were they fired? Because the times are wild, and their corporations were not. Crazy times demand crazy organizations, and the average American organization--including the typical medical society--bores you to death. Sober organizations just aren't going to survive in an unsober economy.

The problems that Peters describes pose significant challenges to a 150-year-old organization like the SMS. You face profound challenges to the way you interact with your patients. That is true whether you practice alone in the heart of downtown Milwaukee or as part of the state's largest multi-specialty clinic in Marshfield.

So, as you may have guessed, I am not going to talk to you this afternoon about medical practice or health system reform. Instead, I am going to spend the next few minutes talking about your organization: What it is today and what it needs to be in the future if it is to remain relevant.

Yesterday, you and your state medical society could get by simply being prudent stewards of a health care system that worked pretty well. In this century alone, the American life expectancy increased from 47 years to 75. But tomorrow will require us to be dreamers, to be entrepreneurs, and to be a little bit crazy. Tomorrow will require us to rethink and reorder our priorities.

Albert Einstein once said that imagination is more important that knowledge, and it seems that the 1990s are proving him right. Ours is not an era in which the SMS should be doing things the way we have always done them. It is time to shake things up.

For instance, government relations--the mainstay of medical societies everywhere for as long as anyone can remember--will not disappear, but will fade. Its importance will diminish partly from health system reform, partly from the realization that with the complexity of massive pieces of legislation we're going to have fewer clear-cut legislative victories, <u>and</u> partly because we are engaging a set of very different-looking competitors, adversaries, and politicians.

The compression of time and the pace of change, that Tom Peters talks about means that our medical society cannot afford to be reactive. We must lead. The future never just happens; it is always created--a fact that provides us with opportunity. The physicians of Wisconsin have a long history of leadership, and I am confident that your tradition of being among the first to identify issues and creatively seek solutions will continue to serve you well.

Although my crystal ball is in the repair shop, there are a few possibilities that seem to have a reasonable chance of becoming realities.

If Microsoft's stock value surpassing that of GM's signifies the passing of the industrial age, it also indicates the dawn of the cerebral age. Information has become a leading national resource, a dominant product in today's economy.

It is likely, then, that one of our focal points in the future will be the continuing education of physicians and their office staffs. There will be new concepts to understand, new procedures to follow and new regulations to observe: And a medical society is an ideal vehicle to act as a clearinghouse for this information.

We can monitor the field, collect and analyze the data, package the information so that the relationships among data from various sources are clear, explain why the information is relevant and present the data in user-friendly form.

We do a great deal of this now, so the future shift in emphasis would be a natural for us.

The need for physicians' office staff training has already led us to start a program that now serves more than 7,000 people annually and has grown, in 4 years, into our Medical Business Specialist Certificate Pro-

gram. We have copyrighted this program and franchised it to other state societies--a success that has already made us unusual for a state-level association, and caused us to broaden our thinking and stretch our sights beyond the natural geographic boundaries of a state association.

Educating the public, and helping you educate your patients, is likely to take on a greater role in medical society activities, too. Public health issues become increasingly important as society as a whole more closely examines where it incurs its health care costs. Tobacco use, alcohol and drug abuse, violence at home and in the streets, sexually transmitted disease, occupational health--these issues and others will begin to occupy more of our time and energy.

Who we are, as well as what we do, is most assuredly going to change. According to a recent Census Bureau report, by the year 2050, nearly half the people in this country will be members of minority groups. By the year 2000, more than three quarters of the emerging work force will be a minority member, a woman, or both.

It is obvious that more persons of color need to be recruited into both medically related careers and association management. It is equally obvious that the lack of role models, the overwhelming cost of education and the continued existence of barriers built on prejudice make this recruitment particularly difficult. Overcoming that difficulty will require the best of our efforts and the most creative of our ideas.

Our changing environment is also likely to cause us to reconsider the way we work with each other, with other medical societies, and with the various publics we are trying to reach.

The federation of medicine will need to clarify the most appropriate and effective roles for each of its components. From the county societies to specialty societies, state societies and the AMA, we must ask: Who is going to do what--and why?

The process of asking those questions, and others like them, began last year when the AMA House of Delegates approved the creation of a "Federation Study Consortium" to analyze the functions, processes, and structural relationships among physician organizations and to recommend improvements.

The goals of this consortium are to create an environment in which all of medicine can better speak with one voice about issues affecting patients and physicians, and to develop mechanisms through which organized medicine can function more efficiently and effectively.

Your state medical society was asked to nominate a representative to this consortium. Dr Susan Turney has been asked to represent us and I am confident that she will do an outstanding job. Although the study is not yet under way, I view it as a positive development.

Internal roles at each of the federation's component societies will also need to be examined. Are our human resources allocated in a way that best meets the new needs of our physician members? Is our organizational structure appropriate for the times? Will our structure and resource allocation allow us to change as times change?

Forming a committee, however, is not exactly the creative response required by these crazy times, so your state medical society has already begun making changes. More than a year ago, we adopted a modified total quality management model that flattened our internal structure. Your medical society staff now has far greater ability to react to changes, detect and respond to member demands and employ much more of their own creativity, skill, and intelligence.

The staff reorganized around a new emphasis of teamwork. Rather

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Thomas L. Adams, CAE

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than having the old departments plowing the same old furrow over the same old turf, we now form specific teams to address specific issues, projects or problems. These teams are formed by bringing together members from various in-house fields and perspectives, and they are led by whomever seems most appropriate for the task.

When Yogi Berra was asked what made a great baseball manager, his answer was simple: "A great team." Likewise, a great medical society can only be created with a great team of physicians and professional staff. I believe that team has been assembled, and I face the new season with great confidence.

As we progress through this new season for medicine, it is likely that we will be moved to look at our very foundations and ask: "Is the society itself built to best serve its members of tomorrow?"

For instance, medicine in Wisconsin is witnessing the creation of many large group practices, some of which may have clinics in eight or 10 counties. What role might the county medical societies--long the foundation of our federation--play if the new physician's first allegiance is to something other than their county of residence? What becomes of the county societies that have no staff, and how can the state society help enhance the role of those that do?

We may also ask: "Is our House of Delegates, organized along county lines, suited to serve the needs of physicians whose economic and practice ties cross county boundaries?" The cry that it is unfair to vest all political power in county delegations when personal loyalties lie elsewhere has its merits. How do we answer that challenge?

Assuming House approval, next year, we will experiment by separating scientific and policy portions of our annual meeting. The hope is that this will allow more physicians to take part in the policy-making discussions and elections. If participation is not increased, then we will need to explore what other policy-making mechanisms can be employed to enhance member involvement in the Society.

The exploration of where the SMS should be heading and what the SMS should be doing has already begun. Last month, the SMS conducted its most detailed survey ever of its members' opinions. That survey is being followed by a series of focus group studies, giving both qualitative and quantitative data.

This data will provide the raw materials for the next phase in the development of a new strategic plan for SMS. The work on the strategic plan will begin this summer. When it is finished, we should have a clearer image of what you would like your medical society to be.

These are extraordinary times, and extraordinary measures are necessary. The first rule must be that there are no rules. Not to dream boldly may turn out to be irresponsible. In times of great upheaval, only the adaptable survive--size and strength mean nothing. Just ask any dinosaur you happen to meet.

In closing, I want to tell you about another meeting held 214 years ago. It was a beautiful sunny morning with a bright blue sky as the Connecticut House of Representatives gathered in Hartford. But at noon the sky suddenly turned gray and by mid-afternoon it was black.

People were frightened. Many of them feared it was the end of the world and fell to their knees to offer a final prayer. Many members of the House clamored for immediate adjournment. But the Speaker of the House came to his feet and silenced his comrades with these words:

"The day of judgment is either approaching or it is not. If it is not, there is no cause for adjournment. If it is, I choose to be found doing my duty. I move, therefore, that candles be brought to enlighten this hall."

Today, it is not difficult to look to the skies over medicine and see dark clouds gathering. Fear and confusion have gripped many among our ranks. Some are ready to panic.

Our duty, however, is here--working for the good of your profession, working for the health of your patients, and working for the future of American medicine. Let candles be brought to enlighten this hall, too. And let us be fierce in our resolve to press on through the darkness.

Thank you.❖

Awards given by the SMS in 1994

EACH YEAR, during its annual meeting, the SMS recognizes leaders in health care, both physicians and non-physicians, who have made significant contributions to the health and well-being of Wisconsin residents. The following awards were presented during the 1994 annual meeting in Milwaukee.

Fifty Year Club

The SMS honors those members each year who have served the profession and patients for more than 50 years. This year, 36 physicians were inducted into the 50 Year Club during the Board of Directors luncheon at the annual meeting. Graduates of the class of 1944 include:

Armin R. Baier, MD, of Wauwatosa
John Bareta, MD, of Waukesha
Henry J. Barina, MD, of Racine
Dean Becker, MD, of Oshkosh
James F. Bigalow, MD, of Merrill
Warren C. Bogle, MD, of Milwaukee
Harry Colgan, MD, of Neenah
Arch E. Cowle, MD, of Madison
Harold Danforth, MD, Oshkosh
Herbert A. Dasler, MD, of Amery
Robert K. Dodge, MD, of Brownsville, Texas
June L. Grinney, MD, of Tucson, Ariz
Leo R. Grinney, MD, of Tucson, Ariz
Raymond Headlee, MD, of Wauwatosa
James T. Houlihan, MD, of Minocqua
Lorraine F. Houslihan, MD, of Minocqua
Roger H. Lehman, MD, of Brookfield
William J. Little, Jr., MD, of Racine
John Mulvaney, MD, of Ridge Manor, Fla
George Nadeau, MD, of Green Bay
Frank J. Pulito, MD, of Milwaukee
Martin H. Sahs, MD, of Hayward
Kendall E. Sauter, MD, of Wauwatosa
Jonathan Slomowitz, MD, of Milwaukee
Max A. Smith, MD, of Madison
Reuben J. Snartemo, MD, of Milwaukee
Lloyd Steffan, MD, of Plymouth
Walter P. Stenborg, MD, of Pewaukee
Ralph E. Teitgen, MD, of Milwaukee
Walton Thomas, MD, of Naples, Fla
Robert F. Thorpe, MD, of Sun City West, Ariz
Marvin Magner, MD, of Milwaukee
Darwin D. Waters, MD, of Lake Wylie, SC
Marshall L. Weber, MD, of Milwaukee
Lloyd P. Williams, MD, of Appleton
Robert G. Wochos, MD, of Green Bay

Kenneth Viste, Jr, MD, (r) receives the Directors Award, the highest honor bestowed by the SMS, from SMS Board Chair Richard Ulmer, MD, (l).

The Director's Award

The Director's Award is the highest award bestowed by the SMS and is granted only on occasion to those who have served with outstanding distinction the science of medicine, physicians and the citizens of the state of Wisconsin.

Kenneth M. Viste, Jr., MD, of Oshkosh, was presented with the Director's Award by SMS Board of Directors chair Richard H. Ulmer, MD, of Marshfield, during the SMS annual meeting in Milwaukee.

Dr Viste was honored for his many years of distinguished service to medicine. He is a former president of the Wisconsin Neurologic Society and the current president elect of the American Academy of Neurology. Dr Viste served as president of the SMS in 1987-1988. Recently, he was elected vice chair of the Chari-

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table Educational and Scientific Foundation of the State Medical Society. As the chair of the Wisconsin Health Reform Task Force of the SMS, he played an important role in the development of Wisconsin Care, a major universal coverage initiative sponsored by the SMS in the current legislative session.

A Wisconsin native, Dr Viste has been advising state and federal elected officials on medical issues for more than 10 ten years. In March of this year, he was selected by Health Secretary Donna Shalala to serve on the Practicing Physicians Advisory Council of the Health Care Financing Administration. He recently completed 7 years of service on the Wisconsin Medical Examining Board, and is currently an advisor on health care issues to Gov Tommy Thompson.

Distinguished Service Award

The Distinguished Service Award has been presented since 1964 in recognition of outstanding contributions to the art and science of medicine by individuals engaged in teaching or research.

John W. Beasley, MD, of Madison, was presented with the honor in 1994 in recognition of his outstanding contributions to medicine through his work to establish and develop innovations to improve access to health care.

Dr Beasley, associate professor in the Department of Family Medicine at the University of Wisconsin Medical School, has earned the respect and admiration of his colleagues through his pioneering work to expand access to health care in under-served areas. In his position in the Department of Family Medicine at the University of Wisconsin, he initiated a family medicine program that provided incentives to medical students for placement in the offices of rural physicians. The value of these efforts was recognized two years ago when the University of Wisconsin established a required primary care clerkship.

As a co-founder of the Wisconsin Institute of Family Medicine (WIFM), Dr Beasley helped to create a summer internship program that places first year medical students in inner city and rural practice sites. He also founded and directs the Wisconsin Research Network (WReN), a nationally renowned model in general practice-based research, linking over 400 Wisconsin primary care physicians located in 60 of the state's 72 counties.

Dr Beasley helped to create the Advanced Life Support in Obstetrics (ALSO) program, an innovative two-day training seminar that provides doctors the opportunity to refresh critical skills in managing obstetrical emergencies. The program has helped family physicians in rural hospitals to continue offering obstetrical care. Recently, ALSO has been touted throughout the country by the American Academy of Family Physicians as a model program for continuing medical education in obstetrics.

Health Leadership Award

The SMS selected Gregory Frigo as the recipient of its 1993 Health Leadership Award. The SMS Health Leadership Award is given annually to an outstanding person in government service in recognition of contributions to the development of health care policies that benefit the people of Wisconsin.

As an administrator with the Wisconsin Department of Industry, Labor and Human Relations, Frigo's career has been marked by a commitment to formulating effective public policy through the inclusion of all concerned parties and consensus building.

Currently serving as the director of the Bureau of Legal Affairs for the Unemployment Compensation Division of DILHR, Frigo held the position of Worker's Compensation division administrator at DILHR from January 1990 to November 1993. During that time, he oversaw the implementation of several initiatives helpful to the general public and the medical community. While also serving as the chair of the Worker's Compensation Advisory Council, Frigo ensured a fair hearing of the concerns of health care providers by securing a seat at the table for an SMS representative during Worker's Compensation Advisory Council deliberations. In addition, he directed the promulgation of administrative rules designed to minimize the frequency of reasonableness of fee disputes and necessity of treatment disputes.

A graduate of UW-Oshkosh and the University of San Diego Law School, Frigo's career of public service at DILHR includes serving as the director legal affairs and administrative law judge for the Division of Unemployment Compensation, the chair of the Unemployment Compensation Advisory Council, and attorney for the Labor and Industry Review Committee.

Erwin R. Schmidt Interstate Teaching Award

Established in 1966, the Erwin R. Schmidt Interstate Teaching Award is given every three years to a physician from Wisconsin who is deserving of special recognition for medial teaching within the boundaries of our state. This year's recipient is Thomas C. Meyer, MD, of Madison.

Dr Meyer received his medical degree from Witwatersrand University in 1950. He completed his internship in Johannesburg, South Africa, and Edinburgh, Scotland. In 1954, Dr. Meyer moved to North America to serve residencies in cardiology and neurology at Johns Hopkins Hospital and the University of Saskatchewan in Canada.

In 1961, Dr Meyer was appointed assistant professor of pediatrics at the University of Wisconsin and, in 1965, was selected assistant dean of the University of Wisconsin Medi-

cal School and chair of continuing medical education. Dr Meyer was appointed associate dean and chair of continuing medical education in 1967 and in 1970, professor of pediatrics and continuing medical education.

Dr Meyer is active in many professional associations including the Association for Hospital Medical Education, American Board of Pediatrics, the State Medical Society and the American Medical Association. Dr Meyer's affiliations at the University of Wisconsin include chair of the continuing medical education committee, member the University Hospital's board, chair of the Educational Improvement Grant Committee, and a member of the Educational Policy Council.

Houghton Award

The Houghton award is presented annually to senior medical students who demonstrate scholastic excellence, extra-curricular achievement, and interest in medical organization. Winners receive a check for $500 and an engraved plaque, both of which are presented at the Society's annual meeting. The 1994 winners were: George J. Rhodes, of the Medical College of Wisconsin, and Kevin E. Wasco, of the University of Wisconsin Medical School.

Beaumont Lecture Award

Established by the SMS in 1957, the William Beaumont Lecture commemorates one of Wisconsin's pioneer surgeons. Sponsored by the SMS Charitable, Educational and Scientific Foundation, it is designed to present to members of the Society, distinguished medical scientists whose research and clinical experience may enrich the knowledge and skills of Wisconsin practitioners. The lecture is given each year during the surgery meeting of the SMS annual meeting to honor William Beaumont, who in the 1830s performed a series of experiments on digestion that laid the foundation for understanding the digestive phenomenon.

The 1994 William Beaumont Memorial Lecture Award was presented to Jeremiah G. Turcotte, MD, professor of surgery and director of the organ transplant center and liver transplant program at the University of Michigan in Ann Arbor.

Medical Issues Reporting Award

Steve Busalacchi was selected to receive the 1994 Medical Issues Reporting Award from the State Medical Society of Wisconsin.

Busalacchi, a medical and political correspondent for Wisconsin Public Radio, has a well-earned reputation for fair and well-balanced reporting. Busalacchi participated in the lay internship program offered through SMS and spent a weekend with Wood County doctors participating in and observing their work.

Established in 1990, the SMS medical issues reporting award is presented to a Wisconsin journalist for in-depth, even coverage of medical issues during the preceding calendar year. Criteria includes quality of writing, depth of research, accuracy, clarity, impact in Wisconsin, fairness and originality.

All print and broadcast reporters covering medical issues in Wisconsin are eligible to receive the SMS award.

Meritorious Service Award

Recipients of the 1994 Meritorious Service Award presented by then-SMS President Pauline M. Jackson, MD, are:

- Joseph C. DiRaimondo, MD, for 9 years of service to the SMS Board of Directors;
- Philip J. Happe, MD, for 9 years of service to the SMS Board of Directors;
- John K. Scott, MD, for 19 years of service on the SMS delegation to the AMA;
- Patricia J. Stuff, MD, for 19 years of service on the SMS delegation to the AMA;
- David G. Benzer, DO, for 9 years of service on the Commission on Addictive Diseases;
- Kathy P. Belgea, MD, for 10 years of service on the Commission on Continuing Medical Education;
- Charles A. Capasso, MD, for 8 years of service on the Commission on Environmental and Occupational Health;
- Paul F. Durkee, MD, for 9 years of service on the Commission on Environmental and Occupational Health;
- Paul E. Hänkwitz, MD, for 9 years of service on the Commission on Geriatric Health;
- Michael C. Reineck, MD, for 10 years of service on the Commission on Governmental Affairs and seven years of service on the Commission on Medical Liability and Risk Management;
- Charles L. Steidinger, MD, for 11 years of service on the Commission on Governmental Affairs;
- Richard H. Christianson, MD, for 8 years of service on the Commission on Health Care Financing and Delivery;
- Charles A. Hammond, MD, for 9

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Steve Busalacchi, of Wisconsin Public Radio, won the 1994 Health Issues Reporting Award.

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years of service on the Commission on Maternal and Child Health;

- Perry A. Henderson, MD, for 9 years of service on the Commission on Maternal and Child Health;
- William V. Dovenbarger, MD, for 8 years of service on the Commission on Mediation and Peer Review;
- Dorothy V. Skye, MD, for 9 years of service on the Commission on Mediation and Peer Review;
- Lucille B. Glicklich, MD, for 7 years of service on the Commission on Medical Liability and Risk Management;
- Kenneth I. Gold, MD, for 4 years of service as vice speaker of the SMS House of Delegates;
- Stephen W. Hargarten, MD, for 9 years of service on the Commission on Safe Transportation;
- Susan K. Kinast-Porter, MD, for 9 years of service on the Commission on Safe Transportation;
- Andrew B. Crummy, Jr., MD, for 9 years of service on the Editorial Board of the *Wisconsin Medical Journal*.

Reference committees: 1994

State and National Issues
James Youker, MD, Milwaukee, chair
Charles Holmburg, MD, Menomonee Falls
William Wood, MD, Madison
James Siepmann, MD, Oshkosh
William Chleborad, MD, Sheboygan
Heather Flanery, MD, La Crosse, alternate

Organization and Finances
Mark Belknap, MD, Ashland, chair
Jim Concannon, MD, Kenosha
Ron Stark, MD, Milwaukee
Elizabeth Sanfelippo, MD, Fond du Lac
James Beix, MD, River Falls
Dannen Mannschreck, MD, Fennimore, alternate

Scientific Activities
Kay Heggestad, MD, Madison, chair
Sally Schlise, MD, Green Bay
John Whitcomb, MD, Milwaukee
Dean Stueland, MD, Marshfield
Wendelin Schaefer, MD, Sheboygan
Anthony Balcom, MD, Milwaukee, alternate

Socioeconomic Activities
Benjamin Wedro, MD, La Crosse, chair
Gerald Gehl, MD, Chippewa Falls
Wayman Parker, MD, Milwaukee
Alan Schwartzstein, MD, Madison
Gurdon Hamilton, MD, Marshfield

Health System Reform
Clarence Chou, MD, Mequon, chair
David Murdy, MD, Janesville
Charles Link, MD, La Crosse
William Yanke, MD, Park Falls
Raymond Johnson, MD, Wauwatosa
Vernon Hunt, MD, Madison

Credentials
Kathleen Wick, MD, Beloit, chair
Steven Azuma, MD, Kenosha
Wesley McNeal, MD, Green Bay❖

President Citation Award

Since 1959, the president of the SMS, with the approval of the Board of Directors, has had the privilege of presenting a presidential citation to a physician or non-physician who has made an outstanding contribution to medicine or public health.

Patricia J. Stuff, MD, of Bonduel, was awarded the 1994 Presidential Citation. Then-President Pauline M. Jackson, MD, of La Crosse, president of SMS, presented the award to Dr Stuff during the medical society's annual meeting in Milwaukee.

A recognized leader among physicians, Dr Stuff has given three decades of service to medical professional associations. She has been a Wisconsin delegate to the American Medical Association (AMA) since 1979, and an alternate delegate from 1977 to 1978. She was selected to serve on the AMA's ad hoc committee on women physicians, the association's first committee of its kind. A former chair of the state's AMA delegation, she is also treasurer of the AMA Women's caucus.

Dr Stuff was the first woman physician to hold an SMS elective office, serving as vice speaker and later as speaker of the SMS House of Delegates from 1973 to 1977. She has served as a member of the SMS Nominating Committee and of the House of Delegates reference committees, and chaired the SMS Committee on Women Physicians. Dr Stuff is the medical director of the Shawano Hospice and the Heartland of Shawano Nursing Home.

In addition to her commitment to

patients and professional associations, Dr Stuff has given many years of community service to the Shawano area. Nearly 20 years ago, she organized a committee of citizens to study the feasibility of establishing an area mental health center which led eventually to the construction of a Shawano County clinic for mental health, developmental disabilities and chemical dependency. For these efforts, Dr Stuff earned the Woman of the Year Award of the Shawano County Business and Professional Women's Association. She also serves on the Board of Directors of Community Programs of Shawano County, and is a former church elder at First Presbyterian Church of Shawano.

Service Recognition Awards
The following physicians have been selected to receive 1994 Service Recognition Awards:

Alfred Dally, MD, of Madison
Scott Erickson, MD, Marshfield
Guenther Pohlmann, MD, Bayside

Physician-Citizen of the Year Awards

District 1--Stephen Hargarten, MD, Milwaukee
District 2--Norval Bernhardt, MD, Madison
District 3--Jeff Flynn, MD, Arcadia
District 4--Tom Peterson, MD, Wausau
District 5--Jerry Salan, MD, Waupaca
District 6--Reynold Nesemann, MD, Kewaunee
District 7--John Simenstad, MD, Osceola
District 8--Joseph M. Jauquet, MD, Ashland

Physician Citizen of the Year 1994 Nominees
The following physicians were nominated by members of their communitites for the Physician Citizen of the Year Award:

Merne W. Asplund, MD, Bloomer
Michael K. Augustson, MD, Beaver Dam
Mark P. Bishop, MD, Dodgeville
Vinoo Cameron, MD, Athens
Douglas D. DeLong, MD, Ladysmith
Paul Dvorak, Madison
Victor Falk, MD, Edgerton
John S. Garman, MD, Waterloo
Brad Garber, MD, Fairchild
Robert J. Glinert, MD, Madison
Kenneth I. Gold, MD, Beloit
Bahri O. Gungor, MD, Neillsville
Perry A. Henderson, MD, Madison
Harold J. Hoops, MD, Green Bay
Eugene R. Jonas, MD, Ellsworth
Edward Kramper, MD, McFarland
Christopher L. Larson, MD, Sheboygan
Larry Larson, MD, Milwaukee
John E. Lent, MD, Fond du Lac
Robert C. Mead, MD, Green Bay
Donald H. McDonald, Winneconne
Judith S. Pagano, MD, Rhinelander
Alfred G. Pennings, MD, Fond du Lac
Dennis J. Saran, MD, Waukesha
William E. Scheckler, MD, Madison
Dan Sherry, MD, Ellsworth
Paul William Sletten, MD, Osceola
Jon Van der Hagen, MD, Ashland
John Warren, MD, Green Bay❖

Guess which baby's mother smoked while she was pregnant.

If you're pregnant, see a doctor now.
Fight low birthweight.
March of Dimes
Campaign For Healthier Babies

March of Dimes Preventing Birth Defects

A CESF guide to gifts

Gifts to the foundation may take a number of forms: cash, bequests, trusts, life insurance, real estate, stock or other securities--some physicians are making the foundation a beneficiary of their wills. Such gifts may be designated as unrestricted or for specific immediate use at the discretion of the foundation trustees. They may also be restricted or earmarked for specific purposes of interest to the donor. Likewise, these gifts may also be designated for permanent investment with only the income used to support foundation programs.

The foundation currently asks for a voluntary donation of $60 from the SMS membership through the membership dues statement and other direct mail solicitations.

Contributions provide financial aid to Wisconsin students of medicine and allied health professions, stimulates research into areas of medicine and public health and promotes the preservation of medical history.

Cash gifts. Most gifts received by the foundation are in the form of cash, and personal checks are made payable to the CES Foundation. These gifts, as well as others, may be designated in honor of a relative, friend or associate. The foundation maintains a memorial program which gives the donor an opportunity to remember someone through a gift to the foundation--a living memorial. A memorial card is sent to the family with the name of the deceased and the name of the donor. The donor will receive a card thanking them for their contribution.

Bequests. A bequest is the giving of property by will. The will is designed to assure that upon death the property is distributed exactly in accord with the donor's wishes. One of the purposes of a will can be to perpetuate the donor's name or that of a friend through an organization such as the CES Foundation.

A codicil is an amendment or revision of a previously executed will. An attorney can draft it with minimal cost should donors wish to add a bequest to the CES Foundation to their will.

Gifts of life insurance. Life insurance offers an easy means to make a substantial gift as well as to provide tax advantages for the donor. The CES Foundation is pleased to offer the Endowment Plus irrevocable insurance program which is underwritten by Transamerica Assurance Company.

With a one-time gift or pledge payment agreement over five years--donors agree to let the CES Foundation purchase an endowment life insurance policy in their name. The CES Foundation will own the policy and be the designated beneficiary.

The contribution is fully tax deductible and there are no personal or medical questions asked and no physical exam is required. For annual gifts as low as $500, a substantial endowment can be created in your name. This insurance concept is a wonderful way to build an endowment for the future needs of the CES Foundation.

Real estate. Any standard form of warranty deed or acceptable quit claim deed may be used to deliver real estate to the foundation.

Stock or other securities. Current gifts may take the form of stock or other securities which have appreciated in value. Gift of appreciated securities permit the donor to realize substantial tax advantages.

Personal property. Some donors prefer to make gifts of art, jewelry, antiques, rare books, furniture, or collectibles of other types such as stamps, coins, etc. For tax purposes, the donor must determine the value of a personal property gift on the date of its transfer to the foundation.

Trusts. Some find it advantageous to make a contribution to the foundation, but retain the income from the contribution for the duration of their life or the lives of others. There are important tax advantages to these

arrangements. The trustee of such "living trusts" may be a bank, trust company or the foundation.

Among the several types of "living trusts" are: annuity gifts; pooled income gifts; unitrust gifts, deferred payment gift annuities, revocable life income plans.

Pooled income fund. The CESF is pleased to announce the establishment of a Pooled Income Fund which currently has three donors in the fund for a total of $42,000. This planned giving opportunity permits the donor to combine the advantage of bequests and lifetime gifts in one package. The gift is commingled with other similar gifts which are held in a fund; hence the name "pooled."

Participants, their beneficiaries, or both, will receive interest income throughout their lives. Upon the death of the investor's last beneficiary, the CESF will receive the principal to reinvest or use for whatever purposes.

If you are interested in the Pooled Income Fund, you are urged to contact your legal adviser, accountant, or Julie A. Hein in the CESF office at 257-6781.

CESF facts

THE SMS CHARITABLE, Educational and Scientific Foundation is a non-profit, non-stock Wisconsin corporation, chartered in June 1955. As stated in the by-laws, the foundation's purpose is to "engage in, assist, and contribute to the support of charitable, educational, and scientific activities and projects and to contribute to the support of, and to create and maintain, charitable, educational, and scientific institutions, organizations, and funds of any and every kind.

Management

The foundation's governing power is vested in a board of trustees composed of directors and officers of the SMS, other medical and non-medical members elected by the board of directors and one representative elected by each component medical society. Non-medical members may be elected from time to time by the SMS Board of Directors, but the number of such trustees shall not at any time be less than five or more than ten.

The board of directors of the corporate trustees consists of 18 members including the president, vice president and treasurer of CESF, and in addition, 12 members, seven of whom may be non-medical trustees, each elected for staggered three year terms.

Registration

The foundation is registered with the Secretary of State as a charitable organization for purposes of contributions and fund-raising under §440.41(2) of the Wisconsin Statutes.

Legal

The foundation retains Robert B.L. Murphy of the firm Murphy & Desmond, SC, 2 E Mifflin St, Madison, WI 53703; (608) 257-7181, for advice on legal and tax matters. Julie Ann Hein serves as the managing director who works directly with the executive vice president and deputy executive vice president of

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AMA Trustee Donald Lewers, MD, answers questions on reform issues.

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SMS and is responsible for all duties of the foundation.

Tax information
Contributions to the CES Foundation are tax deductible under both state and federal tax laws. The foundation is a 501(c)(3) non-profit corporation. As in all matters relating to your financial affairs, the valuation, form and tax aspects of gifts, to the foundation should be discussed with your attorney, accountant or other advisor.

Officers
President: Stephen B. Webster, MD, LaCrosse
Vice president: Kenneth M. Viste Jr, MD, Oshkosh
Treasurer: Richard W. Edwards, MD, Richland Center
Secretary: Thomas L. Adams,* Madison
Finance Committee chair: Richard W. Edwards, MD, Richland Center
Assistant treasurer: John K. Scott, MD, Madison

Directors
Rockne G. Flowers, Stoughton
Helen Hacker,* Marshfield
Julie A. Hein,* Madison
Pauline M. Jackson, MD, La Crosse
J D Kabler, MD, Madison
Russell F. Lewis, MD, Madison
Robert B. L. Murphy, Madison
Marcia Richards, MD,* Milwaukee
Richard Roberts, MD,* Madison
John Suby, CPA, Madison
Eric Temte, Prairie du Chien
Earl R. Thayer, Madison
Janet Treacy, Waukesha
Ronald G. White, Madison
*ex officio

Staff
Managing Director: Julie A. Hein, Madison
Administrative Assistant: Jane Anderson, Madison❖

CESF history

The Charitable, Educational and Scientific Foundation was chartered by the SMS in 1955 as a private, non-profit, non-stock corporation to enable physicians and other friends of the profession to support, through gifts and grants, projects vitally affecting scientific medicine and public health. The foundation's scope of interest has grown because of bequest contributions; therefore, a number of worthy programs affecting medical education and health care needs in Wisconsin can be accomplished. The future of the foundation holds an array of opportunities and challenges.

Benevolent assistance
The CES Foundation is ever sensitive to the needs of people who are the victims of adversity. Although the foundation's capacity in dollars has been limited, it has often been able to arouse the spirit of caring among physicians and the public when special needs arise. Assistance is looked at as an investment in the future and not as charity.

Education
Funding from the foundation's Barbara Scott Maroney Memorial Fund for Research on Diabetes support special research projects, summer camp scholarships for diabetic children, publication of scientific articles or presentation of scientific speakers on the subject.

The foundation makes grants available to organizations striving to stimulate student interest in science and expose them to wide varieties of science related careers. Annually, the CES Foundation recognizes outstanding achievements in student science research by high school and middle school students in Wisconsin through contributions for awards to the Wisconsin Science Congress and the Wisconsin Science Olympiad.

As a project of the county auxiliaries, the Workshop on Health, a health education program for high school students, has featured such topics as anorexia nervosa, eating disorders, sexually transmitted diseases, teen suicide, alcohol and drug abuse, and wellness. Lastly, the foundation has helped to sponsor the "Hands on Health" exhibit at the Madison Children's Museum.

Student loans, grants and scholarships
One of the most important activities of the CES Foundation is the student loan program. Established in 1955, the foundation's general student loan fund is designed to assist needy, deserving students preparing for careers in medicine, dentistry, pharmacy, nursing, and other allied health fields. Long-term, low-interest loans are interest-free until after the student graduates. Personnel in the financial aid departments of Wisconsin medical schools cooperate with the foundation in identifying needy and deserving students.

Many young men and women can achieve their medical careers

only because of the availability of low-interest loans. In fact, the average medical student today can anticipate graduating with debt obligations ranging from $50,000 to $75,000. Through fiscal year ending June, 1993, the foundation granted 74 loans to medical and allied health students for a total of $215,000. Repayments during fiscal year 1992-93 totalled $86,168. Since the loan fund was established, 1302 students have received $1,986,648 in long-term, low-interest loans.

Although the foundation's primary emphasis is in loans, some outright scholarships and grants are made to fulfill the wishes of some donors and the needs of certain potential recipients. These special health career student loan and scholarship funds are administered by the foundation according to the wishes of the individual or organization establishing and supporting the fund.

The Edward W. Vetter, MD Medical Education Scholarship Fund has been established for medical students in all specialty fields of medicine.

A contribution was received to begin the Goodman-Goodell Scholarship Fund. Awards are to be given to a second year medical student from the Portage area planning to specialize in pulmonary or in general or family practice.

Nelson Industries provides a scholarship to an outstanding medical student from an area in which their plant facilities are located.

The Amy Louise Hunter-Wilson, MD Scholarship has been established to assist American Indians who pursue training or advanced education as doctors of medicine, nurses, technicians or in a related health field.

Each year at the SMS Annual Meeting, the CESF awards two Houghton scholarships for the outstanding senior at the University of Wisconsin-Madison Medical School and the Medical College of Wisconsin.

The L.C. Pomainville, MD Fund was created in 1968 by Dr. Pomainville from Wisconsin Rapids for a scholarship award to contestants for papers on medical history. Currently, the award is being administered with the assistance of the Department of History of Medicine at the University of Wisconsin Medical School.

Applications may be procured from the CES Foundation, 330 E Lakeside St, Madison, WI, 53715; or the medical college's financial aids offices. The CES Foundation furnishes an annual accounting to the benefactor or sponsoring organization.

To inquire how you or your organization can establish a special student loan or scholarship fund, contact Julie A. Hein, 330 E Lakeside St, PO Box 1109, Madison, WI 53701; or phone (608) 257-6781 (Madison area) or toll-free in Wisconsin 800-362-9080.❖

Foundation grant allocation

Thanks to the efforts of a tremendous number of physicians, the foundation is supporting a greater number of programs on a broader spectrum.

The list of grants provided by the foundation during this past year spells substantial achievement. Through physician support and leadership, the foundation hopes to encourage similar support from others. With education as its vanguard, the CESF prides itself in supporting medical education, research and history programs.

During 1993, the foundation contributed to a number of worthy projects through unrestricted and restricted contributions:

- Wisconsin Junior Academy to support Wisconsin Science Congress for high school research projects;
- Volunteer Braillists & Tapists, Inc.;
- *Wisconsin Medical Journal* medical student writing contest;
- Madison Children's Museum to sponsor an exhibit entitled, "Hands on Health";
- Barbara Scott Maroney Fund to sponsor a lecture on diabetes;
- Wisconsin Public Health Association for awareness week and centennial;
- Wisconsin Research Network conference;
- Nelson Industries Scholarship for a senior medical student;
- NEWIST for a video on teens and domestic violence;
- UW Department of Entomology for a Lyme disease exhibit;
- Commission on Continuing Medical Education for learning modules;
- UW Department of Surgery for a research project;
- Marathon County Medical Auxiliary to sponsor a family violence conference; and
- J.G. Crownhart Memorial Fund for the *WMJ* July issue.

For further information regarding the CES Foundation, please contact Julie A. Hein, CES Foundation, PO Box 1109, Madison, WI 53701; (608) 257-6781.❖

The Fort Crawford Medical Museum

THE FORT CRAWFORD Medical Museum is unique among educational institutions. Far more than a museum, it stands as a tribute to Wisconsin's physicians who have dedicated their lives to ensuring the health of the state's citizens.

The Fort Crawford military hospital has been designated a national landmark, and is located in Prairie du Chien near the Mississippi River. On this site in the 1830s, Dr William Beaumont carried out his famous experiments on the physiology of digestion.

The actual planning for the museum began in the 1930s when the SMS placed a granite memorial near the crumbling remains of the second Fort Crawford, which had been abandoned in 1872.

The property was deeded to the SMS Charitable, Educational and Scientific Foundation in the 1950s, and the SMS approved the completion of the museum complex. In 1962, the Stovall Hall of Health was added, in honor of Dr William Stovall to provide additional exhibit space.

The museum houses relics of nineteenth century medicine in Wisconsin, including displays of Indian herbal remedies, a drug store, and dentist and physicians' office.

The museum is open Wednesday through Sunday, 10 am to 5 pm, May 1 through Oct 31.

In 1981, the Fort Crawford Medical Museum Endowment Fund was established to provide financial support for the museum. Over the years, more than 200,000 visitors have toured the museum, yet it continues to face financial hardship and is in need of frequent repair.

Named in honor of Dr William Beaumont, the fund has received over $165,000 from a select group known as the Beaumont 500. With a gift or pledge of $1,000, donors receive a specially designed Beaumont medallion.

The goal is to build a trust fund of 500 contributors or $500,000 in monies. The fund is earmarked to provide for the staffing, utilities, repairs and maintenance, new exhibit construction and renovation, and museum promotion.

A future goal is to develop a contemporary medical exhibit that would incorporate healthcare issues.

For more information about the Fort Crawford Medical Museum, please contact Julie A. Hein at the CES foundation at 800-362-9080 or (608) 257-6781.

Beaumont 500 members:

1980

Pierce-St Croix County Medical Society

1981

Mr and Mrs Robert B. Murphy
Guy W. Carlson, MD
W. Bruce Fye, MD
Pauline M. Jackson, MD
Dr and Mrs William D. Janssen
Dr and Mrs T. A. Leonard
E. J. Nordby, MD
Karver L. Puestow, MD
John D. Riesch, MD

1982

anonymous

John Beasley, MD, won the 1994 Distinguished Service Award.

Marion Crownhart
E. M. Dessloch, MD
Melvin F. Huth, MD
Michael F. Ries, MD
E. A. Steffen, MD
Kenneth M. Viste, Jr, MD

1983

W. Bradford Martin, MD
Earl R. and Alice Thayer

1984

Dr and Mrs K. Alan Stormo
Dr and Mrs Chesley Erwin
Dr and Mrs Leonard B. Torkelson
Leland C. Pomanville, MD
Mrs W. D. Hoard
Dr and Mrs Ralph Hudson

1985

Dr and Mrs Roger von Heimburg
Dr and Mrs Bertram H. Dessel
Mace Garrison Zinggeler
Dr and Mrs Benjamin Brunkow
Robert T. Cooney, MD
Staff of the State Medical Society of Wisconsin

1986

Dr and Mrs William Listwan
Richard W. Edwards, MD
Amy Hunter-Wilson, MD
Kari, Doran and Kenneth Viste
Roy Selby, MD

1987

Sandra Osborn, MD
Timothy T. Flaherty, MD
Washington County Medical Society
Dr and Mrs Roland R. Liebenow
Racine County Medical Auxiliary
State Medical Society of Wisconsin

1988

Jefferson County Medical Society
Milwaukee County Medical Auxiliary
Milwaukee County Medical Society
Dr and Mrs Victor Wong
Physicians Insurance Company of Wisconsin
Dr and Mrs Ken Smigielski
Kenneth M. Viste, Jr, MD, in honor of the SMS staff
Joan Flaherty
Edward A. Burg, Jr, MD, family
SMS Services, Inc

1989

Dr and Mrs Stephen Webster
Dr and Mrs Kermit Newcomer
Sauk County Medical Society
Wood County Medical Society
Dr and Mrs John D. Wegenke
La Crosse County Medical Society Auxiliary

1990

Green County Medical Society
Winnebago County Medical Society Auxiliary
Dr and Mrs Louis Hacker

1991

Brown County Medical Society Auxiliary
Dr Robert and Roberta Baldwin
Cyril M. Hetsko, MD and Theresa M. Hottenroth
Dr and Mrs J D Kabler
State Medical Society of Wisconsin Auxiliary

1992

Columbia, Marquette, Adams Medical Society
Dane County Medical Society
Eau Claire, Dunn, Pepin Medical Society Auxiliary
Fond du Lac County Medical Society
Fond du Lac County Medical Society Auxiliary
Dr and Mrs Gerald C. Kempthorne
La Crosse County Medical Society
Patricia J. Stuff, MD
Vernon County Medical Society
Waukesha County Medical Society Auxiliary
Dr and Mrs David Weber
Winnebago County Medical Society
Dr and Mrs Raymond C. Zastrow

1993

Dr and Mrs Joseph C. DiRaimondo
Marathon County Medical Society
Richland County Medical Society
Dr Robert and Laura Roberts
Dr Ken and Jan Viste

Beaumont 500 pledges

Thomas and Diane Adams
Manitowoc County Medical Society Auxiliary❖

American Academy of Pediatrics

Child Safety Tips

Injuries have been the leading cause of death in children, adolescents and young adults for nearly 40 years. This year, one out of every four children in the U.S. will suffer an injury serious enough to require medical attention.

The American Academy of Pediatrics is working to reduce childhood injuries. As part of the effort, the nation's 45,000 pediatricians have declared October as **Child Health Month**. Together we can place solutions before problems. Here are a few safety precautions to start with.

- **Give your home a safety check.** Use smoke detectors. Turn down your water heater to 120°. Use window guards and stairway gates. Never leave children alone in the tub. Store poisonous cleaners, chemicals, matches, lighters and small objects out of reach. Use childproof caps on medicines. Don't use baby walkers. Know how to access emergency services. Learn CPR. If you have a gun, keep it unloaded and locked away.

- **Help your children to be safer.** Buy bike helmets and insist they wear them. Children up to age 4 should be in safety seats when in vehicles. All others should wear safety belts. Install a 4-foot-high, 4-sided fence with a self-latching gate if you own a pool or hot tub. Inspect playgrounds for hazards such as concrete or hard dirt surfacing under climbing equipment.

For more information, send a stamped, self-addressed envelope to: *Safety Tips*, Dept. C, American Academy of Pediatrics, P.O. Box 927, Elk Grove Village, IL 60009-0927.

They know why they can't. Now tell them how they can.

Too many older smokers are still making excuses instead of making a determination to quit. And while most of them know about the more common long term effects of smoking, far too few of them know the facts about the immediate health benefits of quitting.

As a doctor, you can play a unique role in getting your older patients who smoke to quit for good. Take a little extra time and educate your patients about the immediate benefits of quitting. Like a decreased risk of heart attacks and strokes. Improved circulation. And most of all, the years they can add to their lives.

So listen to their reasons for not quitting, then go ahead and give them the facts.

Let them know: it's never too late to quit.

For a free copy of "Clinical Opportunities for Smoking Intervention: A Guide for the Busy Physician," complete the form below.

Mail to:
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4733 Bethesda Avenue, Suite 530, Bethesda, MD 20814
(301) 951-3260

Name _____

Specialty _____

Address _____

_____

U. S. Department of Health & Human Services

SMS headquarters gains new security system

As of July 1, visitors to the SMS headquarters in Madison will encounter a couple of changes in the building security system. The changes are necessary responses to a world and a body of tort law that are not always changing for the better. The SMS has, however, worked to keep these changes as unobtrusive as possible. The goal is to provide the SMS staff, members, and visitors a greater level of security without undue disruptions.

The change that will be most noticeable to you is that when you enter the SMS building, you will be asked to clip on a member name tag. If you are attending a scheduled SMS activity, such as a commission meeting, you will find a preprinted name tag waiting for you. If you are just dropping in or have an appointment with a member of our staff, you will be asked to stop at the front desk and pick up a badge, and to drop it off at the front desk as you leave the building.

All SMS staff and all visitors will also be wearing name badges while they are in the building.

One positive side effect of the new system will be that the entire staff will immediately recognize you as a member physician. Few of the staff have the opportunity to meet physicians in the field or at meetings, but during the course of a typical year more than 1,000 physicians visit the SMS headquarters, and we hope the new system will enhance the value of those visits. Getting to know you better is one of the first steps in intensifying the SMS service-to-members philosophy.

Another change you may notice is that all exterior doors, except the main entrance, will be kept locked at all times (as will the door to our main computer room). The front door will be unlocked during normal business hours. Surveillance cameras, operating around the clock, will keep an eye on all doors and loading docks.

Don't worry: The SMS has not experienced any serious security problems at SMS headquarters. We would like to keep it that way.

Pick up any newspaper, turn on any news broadcast, and the trend toward a more violent America is evident in the headlines. Part of the increased violence in America is found in the work place—so much so that counseling employers on the legal issues associated with work place violence has become as much as 10% of some law firms' business. Last fall, the Society of Human Resource Management surveyed 479 companies: more than one third reported violent incidents at work. In 1992, work place violence cost employers an estimated $4.2 billion in lost work and legal expenses.

Not only does violence damage the lives of valuable employees, it can burden the employer with higher costs for health care, lawsuits, Workers' Compensation premiums and other expenses.

The legal liability threat is not insignificant. An emerging body of tort law suggests that companies large and small should adopt policies and procedures that better define what they are doing to prevent work place violence. The courtroom terms are usually something like "failure to exercise reasonable care and due diligence." (As with other legal employment standards, this applies with equal force to physician offices.) The new security system is an effort to exercise that care and diligence, and thereby protect SMS assets from legal threats.

The new procedures should not make your visits to SMS headquarters any less pleasant or productive, but any time a new system is implemented "bugs" are discovered and must be worked out. If the new system creates a problem, please let the staff know.❖

Self-Therapy for the Stutterer

The 192-page book explains how stutterers can help themselves. Ask for book #12 and enclose $3.00 for postage and handling.

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Physician briefs

The * indicates a member of the SMS.

Masood Akhtar, MD, of Elm Grove, is the newly elected president elect of the American Heart Association of Wisconsin. Dr Akhtar is a professor of medicine at UW Medical School--Milwaukee Clinical Campus; director of arrhythmia service and clinical electrophysiology at Milwaukee heart Institute, Sinai Samaritan Medical Center; and staff electrophysiologist at St Luke's Medical Center in Milwaukee.

Toni Almond, MD,* of Wausau, recently joined Merrill Medical Associates, SC, specializing in the practice of internal medicine with critical care emphasis. Dr Almond received her medical degree from the University of Missouri-Columbia in 1987. She completed her internship and residency at the University of Missouri. Dr Almond is board eligible in internal medicine.

Steven Armus, MD, has joined the staff of Lakeland Medical Center's Outpatient Club. Dr Armus attended the University of Wisconsin Medical School and completed his internship at Morristown Memorial Hospital. Prior to coming to southeast Wisconsin, he completed a 3 year residency in dermatology at State University of New York in Buffalo.

Paul A. Capelli, MD, a specialist in obstetrics and gynecology who has practiced in Kenosha for more than 30 years, has been hired as the medical director of the Aurora Health Care Center there. Dr Capelli will be responsible for recruiting physicians, maintaining quality of care, community relations, planning and establishing the clinic's insurance contracts.

Thomas Driscoll, MD, of Wauwatosa, has been named senior vice president for medical affairs at St Joseph's Hospital in Milwaukee. For the past 20 years, Dr Driscoll has served as an active member of the St Joseph's Hospital medical staff, as an internist specializing in endocrinology.

Nicholas Gianitsos, MD, a urologist, has been awarded certification as a diplomate of the American College of Urology. Dr Gianitsos earned his medical degree from the Boston University School of Medicine and completed his internship and residency at the University of Wisconsin Hospital and Clinics in Madison.

Kurt Landauer, MD, a family physician, has joined the staff of Marshfield Clinic-Lakeland Center. Dr Landauer, MD, earned his medical degree from the University of Wisconsin Medical School. He served his residency in family practice at the University of Minnesota-Riverside Unit in Minneapolis.

A. James Liedtke, MD, professor of medicine at the University of Wisconsin Medical School, is the newly elected president of the American Heart Association of Wisconsin.

Florentino Lleva, MD, was recently honored for providing excellent health care for more than 30 years at the Arcadia Medical Center. Dr Lleva is a past president of the Tri-County Medical Society, past president of St Joseph Hospital's medical staff and chief surgeon at St Joseph's Hospital. He now practices with Memorial Medical Hospital in Neillsville.

Paul McGinnis, MD, of Hudson, was recently named medical director for HMO Midwest. In practice with Hudson Physicians, Dr McGinnis is a second vice president of the Hudson Medical Center board of directors and medical director of Hudson Medical Center Hospice.

Robert McNutt, MD, has joined the faculty of the University of Wisconsin Medical School's Milwaukee clinical campus at Sinai Samaritan Medical Center. Dr McNutt is director of clinical health services research for Aurora Health Care.

Gilbert Nock, MD,* a psychiatrist, has joined Wisconsin Community Mental Health Counseling Centers, working out of its Grafton and Hartford clinics. A graduate of the Marquette University medical school, Dr Nock resides in the Cedar Grove-Belgium area.

Philip A. Swanson, MD, has joined the staff of Marshfied Clinic-Chippewa Center. Dr Swanson, an anesthesiologist, earned his medical degree from the University of Illinois College of Medicine in Chicago. He served his residency in anesthesiology at Wilford Hall U.S. Air Force Hospital in San Antonio.

Jonathan Towne, MD, has been selected to receive the Distinguished Service Award from the Medical College of Wisconsin. The award honors Dr Towne's contribution as chair of vascular surgery and his 19 years of service to the Medical College.

Jerome Veranth, MD, a board-certified otolaryngologist has joined Rhinelander Medical Center. Formerly in practice in Racine, Dr Veranth earned his medical degree at Marquette University and served a general rotating internship at St Mary's Hospital in Duluth. He completed his residency in otolaryngology at Marquette, and has served as an instructor and professor for the Medical College of Wisconsin.❖

County society news

Dane. The following members have been accepted by the Dane County Medical Society: James Andersen, MD; Richard Auchter, MD; Mark Bogner, MD; David Chakoian, MD; Michael Garren, MD; Lynn Hahnfeld, MD; Philip Kober, MD; Kenneth Lay, MD; Mark Moffett, MD; Bruce Potenza, MD; Ann Schmidt, MD; Michael Sheehan, MD; and Susan Toth, MD.

Fond du Lac. The Fond du Lac County Medical Society Meeting was held April 28, 1994, at the South Hills Country Club. Newly elected president of the SMS, Dr Richard Roberts, spoke on the major thrust of his presidency this year, hand guns and children. Information was presented about the mini-internship program, designed to provide an opportunity for local businessmen, politicians and community leaders to join a physician during a routine work day to better understand the daily life of a physician. The current Fond du Lac County Medical Society vice president, Dr. Yuhas, has decided not to serve as president next year. Anyone interested in serving a leadership role in the society should contact Dr Strigenz.

Oneida-Vilas. The Oneida-Vilas County Medical Society met on May 24, 1994, at the Claridge Motor Inn in Rhinelander. The guest speaker was Rep. James Holperin, who spoke on his experiences as a legislator for the past 12 years. The next meeting will be held in the fall, probably in the Eagle River area in October. The guest speaker will be Dr. Richard Roberts.

Washington. The Washington County Medical Society approved membership for the following physicians: Mary C. Fernandez, MD; Patricia J. Liethen, MD; Paul R. Glunz, MD; Rajesh Kumar, MD; Jeffrey H. Lovell, MD; and Jefferson D. Watts, MD.❖

Obituaries

Bachhuber, Max O., MD, died April 20, 1994. He was born Feb 28, 1906, in rural Clark County. He graduated from the UW-Madison Medical School. He practiced medicine in the Alma area from 1936 until 1978, when he retired. He also served as Buffalo County coroner. Dr Bachhuber was a member of the American Academy of Family Practice, a life member of the SMS, and a member of the Trempealeau-Jackson-Buffalo County Medical Society and AMA. He is survived by two daughters, Susan Smith, of Milwaukee, and June Ellen Landmesser, of Sarasota, Fla; one son, Max Bachhuber, of Alma; five grandchildren; one great-grandson; and one sister.

Cupery, Dowe P., MD, died June 2, 1994, in Markesan, where he was a family practitioner for 35 years. He graduated from Marquette University Medical School in 1939. He was a member of the Green Lake County medical Society, SMS, AMA, and the American Association of Family Practitioners. He and his wife served as medical missionaries in Ethiopia in 1963. He also served on the medical staff of Waupun, Ripon, Beaver Dam, and Fond du Lac Hospitals. Dr Cupery is survived by his son, Dr James Howard Cupery, of Eau Claire; four daughters, Susan, of La Crosse, Jo Anne, of Beaverton, Ore, Diann, of Lancaster, and Nancy, of Edina, Minn; 10 grandchildren, one sister and one brother.

Continued on next page

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

Continued from preceding page
Johnson, John M., MD, died May 8, 1994, in Oconomowoc. He was born Aug 8, 1896, in Wheaton, Minn. He graduated from Northwestern University Medical School in 1924. Dr Johnson practiced medicine in Ripon until his retirement in 1985. He was a life member of the SMS. Dr Johnson is survived by his daughter, Joyce Chapman of Oconomowoc; four grandchildren, and five great-grandchildren.

Lakritz, Leo W., MD, died May 12, 1993, in Beloit. Dr Lakritz had two careers: musician and physician. He was born in Milwaukee and was a scholarship student at the Julliard School in New York. His education there was interrupted by 4 years of service during World War II in the Army Air Force. Upon discharge, he returned to New York and was engaged as a professional musician by Leonard Bernstein for the New York City Symphony. He was a member of the orchestra for the City Center Opera Company. His instrument was the clarinet. He also played in the New York Philharmonic under Bruno Walter and Dimitri Mitropolous. His second career began with graduation from the Marquette University Medical School in Milwaukee. This was followed by a residency in ophthalmology at the Illinois Eye and Ear Infirmary. He established a practice in this specialty in Beloit in February, 1959. He retired in 1990. He was a member of the SMS and the Rock County Medical Society. Dr Lakritz is survived by his wife, Esther; three children, Simeon of San Diego, David of San Mateo, and Naomi of Winnipeg, Canada; three grandchildren; and his brother.

Polacheck, Walter S., MD, died May 3, 1994, at the age of 83. He was a practicing pediatrician for 50 years in Shorewood. Dr Polacheck received his medical training at Rush Medical School in Chicago. He was a life member of the SMS and a member of the Medical Society of Milwaukee County. He is survived by his wife, Rosalie, and his children, John W. of Tucson, Ariz; Linda P. Mellis of Chicago, Mary Ickes of Salem, Ore, Tom Polacheck, of Hobart, Australia, and Andrew Kops of London, England; and nine grandchildren.

Rudman, Daniel, MD, died April 17, 1994, in Wauwatosa. Dr Rudman, an endocrinologist, geriatrician, and nutritionist, was an associate chief of staff for extended care at the Zablocki Veterans Affairs Center and a professor of medicine at the Medical College of Wisconsin. Dr Rudman received his medical degree in 1949 at Yale University School of Medicine. He completed his residency training in medicine at Columbia University and served a research fellowship at the New York Heart Association. He held faculty appointments at Columbia University College of Physicians and Surgeons, Emory University School of Medicine and the University of Health Sciences-The Chicago Medical School, before joining the Medical College of Wisconsin in 1988. Dr Rudman is survived by his wife, Inge; a daughter, Nancy, San Jose, Calif; a son, Richard Rudman, Boston, and a brother.

Sanfelippo, Anthony J., MD, died May 16, 1994, in San Diego. He received his medical degree from Marquette School of Medicine in 1938, at which time he opened his private practice. He served as a surgeon in the Army from 1944 through 1946. Dr Sanfelippo was a member of the Wisconsin Medical Examining Board from 1969 through 1973, serving as chair in 1972. He was chief of staff at St Mary's Hospital from 1970 through 1972, and was later named chair of the hospital's executive committee in 1972. Dr Sanfelippo was a member of the SMS 50 Year Club, the Medical Society of Milwaukee County, AMA, and the Milwaukee and Wisconsin Academy of Family Physicians. He is survived by his daughter, Mary L. Sanfelippo of Escondido, Calif; two sons, Anthony J. Sanfelippo, Jr., of Fond du Lac, and John F. Sanfelippo of Jefferson City, Mo; one brother and two sisters.

Scheunemann, Wallace E., MD, died May 18, 1994 at the age of 77. He received his medical degree from Marquette University in 1950, and completed his ophthalmology residency at the former Milwaukee County Hospital. He established his practice in West Bend, and was a staff member of Sinai Samaritan Medical Center in Milwaukee, Children's Hospital of Wisconsin, John Doyne Hospital in Wauwatosa, St Joseph's Community Hospital of West Bend, Hartford Memorial Hospital and the former St Alphonsus Hospital in Port Washington. Dr Scheunemann is survived by his wife, Marion; three children, Jean Schacht and Mary Rozek, of West Bend, and Kay Eggert of Appleton; and 12 grandchildren.

Schroeder, Charles Morrison, MD, died in Milwaukee May 5, 1994. He was born July 11, 1908. He received his medical degree at Washington University, St Louis, and served a surgical residency at Louisville City Hospital. He served as a medical officer in the Army from 1940 through 1946. Dr Schroeder was on the surgical faculty of the Marquette University School of Medicine. He had been on the staffs of Milwaukee County General, Veterans Administration, Columbia, and St Luke's hospitals. He retired as professor of surgery, emeritus, from the Medical College of Wisconsin in 1978. He was a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons and he had been president of the Wisconsin Surgical Society of the Milwaukee Academy of Surgery and of

the Milwaukee Academy of Medicine. He was a member of the SMS, AMA, and the Medical Society of Milwaukee County. He is survived by his wife, Lillian, his sister, Jennette Schroeder of Racine, a brother, John M. Schroeder, MD of Madison, a stepson, Joel Lefton of St Louis, and four grandchildren.

Yatso, Michael G., MD, died April 20, 1994. Dr Yatso graduated from Marquette Medical School and specialized in obstetrics and gynecology. He was a physician for Wisconsin Electric Power Company. Dr Yatso received his medical degree from Marquette University and served an internship at Misericordia Hospital in Milwaukee. He is survived by he wife, LaVerne; seven daughters, Kathryn, Laguna Beach, Calif, Susan, Ellen, Jayne, and Judith, all of Wauwatosa, Jeanne Isherwood of Germantown and Bette of Laguna Beach; two sons, James of Wauwatosa and John of Germantown; one granddaughter and two sisters.❖

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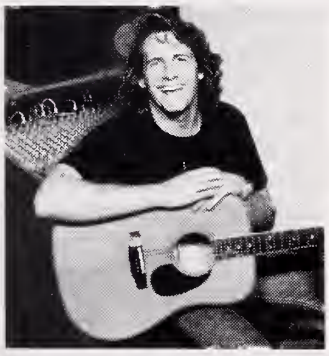

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(c) _____ *my body for anatomical study, if needed.*

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THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

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COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

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Medical Meetings-Continuing Medical Education

Sepcialty Societies

September 9-11, 1994: Wisconsin Society of Anesthesiology, Wyndham Hotel, Milwaukee, WI.

September 17-18, 1994: Wisconsin Allergy Society, Concourse Hotel, Madison, WI.

September 17, 1994: Wisconsin Society of Pathologists, The American Club, Kohler, WI.

September 22-24, 1994: Joint meeting Wisconsin Society of Internal Medicine and Wisconsin Chapter: American College of Physicians, Lake Lawn Lodge, Delevan, WI.

September 23-24, 1994: Wisconsin Academy of Ophthalmology, Wisconsin Dells.

September 30, 1994: Wisconsin Chapter: American College of Cardiology, State Medical Society headquarters, Madison, WI.

October 7-8, 1994: Wisconsin Psychiatric Association, Holiday Inn, Appleton, WI.

October 7-9, 1994: Wisconsin Society of Otolaryngology-Head & Neck Surgery, Lake Lawn Lodge, Delevan, WI.

October 14-15, 1994: Wisconsin Radiological Society, Concourse Hotel, Madison, WI.

October 15, 1994: Wisconsin Society of Radiation Oncologists, Concourse Hotel, Madison, WI.

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December 4-7, 1994: Interim House of Delegates, Honolulu.

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Contents

August 1994 Vol. 93 No. 8

Opinions

405 *President's page*
All aboard the ship of reform? (Due in DC means doin' DC)
by Richard G. Roberts, MD, JD, Madison
408 *EVP report: The view from here*
Stumbling in the dark
by Thomas L. Adams, CAE, Madison
410 *Letters*
WMJ article on surgeons and HIV prompts concern
by Charles E. Gessert, MD and Terrance G. Brennam, MPH, MATEC
410 Physician petition leads to changes at WIPRO
by John J. Kief, MD and Greg E. Simmons, WIPRO
412 Joy is the only perfection
by Victoria Lewin-Fetter, MD, Milwaukee

Scientific

415 Newborn screening for cystic fibrosis in Wisconsin: first application of population-based molecular
by Philip M. Farrell, MD, PhD; Richard A. Aronson, MD, MPH; Gary Hoffman, MS; and Ronald H. Laessig, PhD, Madison
422 Outpatient vaginal hysterectomy in a community hospital
by Matthew A. Meyer, MD; Roger A. Lalich, DO; Margaret M. Meyer, RNC, MS; and Judy Widener, RN, Waukesha
426 Mobitz Type II heart block presenting as weight loss
by Charles E. Wirtz, MD, and John Hayes, MD, Marshfield

Socioeconomic

429 Quality of care: Joining forces to define it
by Norman W. Hoover, MD, Milwaukee
433 The SMS-CESF Medical Outcomes Research Project
by Jerry M. Ingalls, MD, Sally L. Wencel, JD, and Peter J. Alles, MPA, Madison
438 New fraud and abuse safe harbors
by Alyce C. Katayama, JD, Milwaukee
441 *Public health*
Arsenic in private drinking water wells in Outagamie and Winnebago counties, Wisconsin
by Jay Goldring, PhD; Terry Haupert, BS; and Rick Stoll, BS, Madison and Green Bay
444 Physician satisfaction with the development of HMOs in Dane County: 1983-1993
by William E. Scheckler, MD; Rockwell Schulz, PhD; and Paul Moberg, PhD, Madison

Organizational

447 SMS issues call to action on health system reform
448 Dr Roberts carries SMS message to Washington
449 SMS board approves plan for joint conference on gun violence
449 Wisconsin delegation carries resolutions to AMA
450 Court reinstates MinnesotaCare challenge
450 Physician briefs
454 County society news
455 Obituaries

Our cover: Our cover story begins on page 415. Cover photo from Comstock Photo of New York.

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President's page

All aboard the ship of reform?

(Due in DC means doin' DC)

THE SHIP OF health system reform recently sailed up the Potomac and made a port-o-call in Washington, DC. After nearly 18 months of navigating stormy seas and treacherous reefs, many doubted whether the vessel could hold together long enough to make port. During the final few weeks before docking, a number of us were asked aboard to help get the boat through the final shallows. Three visits to the ship of state in 4 weeks taught me a few lessons about political seamanship.

One found all manner of humanity, both noble and nefarious, on the wharf and jetty. Officers, loyal crew, touts, and pirates mingle cheek by jowl amidst the cacophony of a busy seaport of ideas. The tyro was easily distinguished from the old tar: fresh scrubbed, awestruck, and possessed of idealistic optimism. Permit me to share a few insights about these seafaring denizens.

Captain Clinton had charted a course that had moved the ship further than any previous pilot. His officers, the other ship leaders, jockeyed for the best position aboard ship. None completely believed his navigational calculations. Some, such as Lieutenant Dole, openly challenged his plot and threatened mutiny. Even stalwarts grew queasy as the ship lurched and rolled toward its destination. Pilgrims lined in wait for brief audiences with one of the 535 officers, who spent most of their time locked in their cabins while they debated affairs of state. The officers lacked a familiarity with the health system waters provided little solace for the pilgrims and highlighted the officers' dependance on their loyal crew. The conflicting and confusing compass settings by the officers of this ship of health reform suggested that they had lost their way or needed to spend more time in reform school.

Richard G. Roberts, MD, JD

The loyal crew spoke knowingly of the ways of the sea. Yet, they did not have the experience on the water, nor had they ever experienced

Continued on next page

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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Continued from preceding page
the dangers or delights of far-off lands. They were expert however, at pointing out the shoals and other hazards for their officers. Their expertise was gleaned solely from reading and from galley gossip; their hands were smooth, never having pulled a rope.

The touts represented all sorts of interests. Their expense-accounted days were a distillation of *Washington Post* headlines, CNN news briefs, and insider information. They plied the dockside warehouses seeking out officers and crew, like sailors on leave in search of rum. They became masters at the art of reception; master marketers with complex issues reduced to one-page memos and 2-minute corridor conversations. The game was the name of the game--the touts concerned themselves more with the rituals of the game and with being players than whether a goal was scored.

More dangerous were the pirates. They arose from every type of human kind (including former officers, crew, and touts). Their appetites were rapacious; there was nothing they were reluctant to plunder. Truth was a relative commodity, often hidden behind veils of deceit.

It became difficult at times to know the proper heading, much less stay the course. My tailwinds were the collective dreams of Wisconsin physician's and their patients. So long as I kept the proper tack, I felt as though good progress could be made. It felt at times as though we were in the midst of a titanic struggle to correct the course, if only a few millimeters, of a huge ocean liner that threatened to run aground.

The ship has taken on additional provisions in anticipation of the next voyage. The painful lessons learned and the risky nature of the investment make us doubt whether we should ever leave the comfortable familiarity of *terra firma*. The distant shore can seem barely visible, almost a mirage. The belief that we can reach a better place where everyone has access to affordable health care helps to steady the rudder. Nevertheless, we worry about the seaworthiness of our vessel. My hope is that we have not climbed aboard a ship of fools. I wish us all safe sailing.❖

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EVP report: The view from here
Stumbling in the dark

THE CHINESE PHILOSOPHER Lao Tsu wrote that a journey of a thousand miles begins with a single step, but this past week 833 miles seemed like a light year. The usual Capitol chaos has escalated to utter confusion, and the distance from Madison to Washington never seemed longer. So much of what Congress was receiving in the way of health system reform was so big, so complex, and so late that it became impossible to know who stood where on what, what was contained in which, and what to say about anything.

Proposals and accusations were flying, bills were being rewritten several times over even before the original drafts were finished, and the normal processes of Congress broke down. Health system reform was removed from the hands of congressional staff members, taken behind tightly closed doors, and transformed into a series of bitter battles among congressional leaders.

In Lao Tsu's metaphor, Congress began its journey by tripping and falling flat on its face. (Followed, of course, by a loud argument over whose fault it was.)

Things got so crazy that the AMA Board of Directors voted to back a bill that was still being drafted. This bi-partisan bill does not go far enough, particularly with regard to universal coverage, but it does have the tactical advantage of being bi-partisan.

I have been impressed with the SMS Executive Committee's willingness and ability to stay abreast of the quickly changing conditions in Washington via a series of teleconferences. The Executive Committee has tentatively given its support to this same bi-partisan bill in the hope that it can serve as a first step on a more meaningful journey. Meanwhile, physician leaders and SMS staff have been to the Capitol several times during the past weeks, and I am leaving for Washington even as I write this report.

The SMS has not wavered from the eight essential elements of reform (see page 447). How does this bill match with those elements?

Universal coverage
The bill does not achieve universal coverage, and does not purport to be a comprehensive plan for universal access and coverage. There is a soft trigger if coverage of 95% is not achieved by 2002. Under the soft trigger provision, a commission would be responsible for advising Congress on how to achieve universal coverage. It does require employers with more than one employee and who has been an employer for more than 2 years to offer employees an annual group health plan containing a minimum benefits package. At the employee's option, a wage reduction of plan premiums would be available. Access to health coverage for the uninsured and Medicaid recipients is guaranteed through the creation of community health centers using state and federal Medicaid funds. Medical IRAs also would be available to those choosing to use them.

Right to choose
The bill is a managed competition bill, but requires that a point-of-service plan be offered, thereby preserving the right of patients to see their own physician. The bill preempts state any-willing-provider laws, as well as any state laws that are anti-managed competition in nature.

The bill includes language from the proposed Patient Protection Act with regard to grievance procedures disclosure, due process notice and review, and utilization review standards, and prohibits discrimination based on health standards.

Thomas L. Adams, CAE

Standard benefits package
The bill provides that small employer health plans must be designed to provide standard coverage with substantial cost-sharing, or provide catastrophic coverage. Standard benefits packages provide benefits limited to payment for hospital care and physicians' services, diagnostic, limited preventive services, and some mental health services.

Community rating
Based on the language obtained so far, the bill does not have provisions for community rating.

Insurance reforms
The bill requires insurers to make available to all small employers a standard and catastrophic health

plan. The insurers may allow a 6-month pre-existing condition limit for conditions diagnosed or treated more than 3 months before coverage except for pregnant women and newborns. Insurers must accept every small employer in the state that applies for coverage and must enroll every eligible individual who applies for enrollment. HMOs may limit the employers and individuals that may apply for coverage to those with eligible individuals residing within the service area of the plan. Insurers may not cancel or deny coverage except for non-payment of premiums, fraud or misrepresentation, non-compliance with plan provisions or misuse of provider network provisions. Within 90 days of enactment, the National Association of Insurance Commissioners will develop model regulations specifying standards with respect to guaranteed availability of health plans, standard an catastrophic coverage, consumer protection and limits on premiums and annual premium increases.

Portability

The bill provides that plans may not deny coverage for pre-existing conditions to individuals who received continuous coverage for the condition prior to enrolling in a new plan.

Tort reform

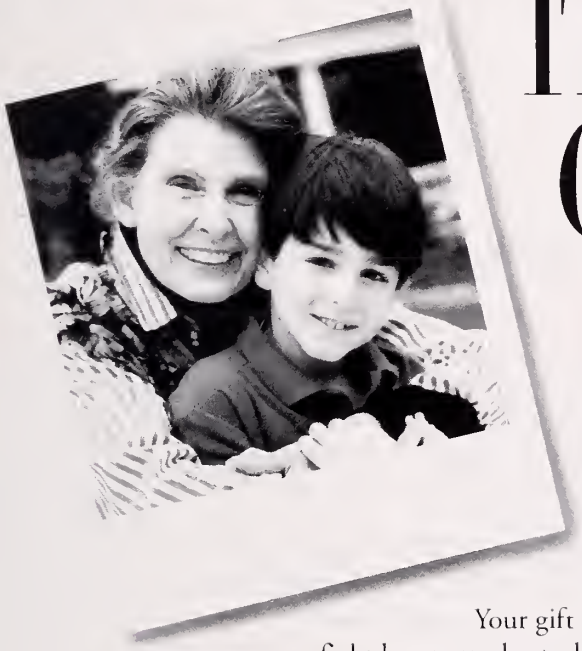
The bill includes many of the MICRA reforms long advocated by organized medicine. In addition to a $250,000 cap, the bill provides for alternative dispute resolution, filing of a certificate of merit of the claim, periodic payments for future losses, maximum contingency fees at 25% of the award, and practice parameters as affirmative defenses.

Fee negotiation

The bi-partisan bill includes limited anti-trust reform, including attorney general guidelines and Department of Justice issue certificates of public advantage.

The bi-partisan bill calls for Medicare cuts of $54 billion over 5 years. The cuts are not specified in any language that is currently available.

At this writing, the Senate threatens to go into round-the-clock session to address health system reform, while the House is preparing to adjourn until the second week of September. Did I hear someone say "hurry up and wait"? Members of the House will likely get an earful from their constituents when they get home, and it is imperative that your voice is part of what they hear (see page 448). Of Wisconsin's congressional delegation, Rep Peter Barca, Rep Tom Barrett, Rep Steve Gundersen and Sen Herb Kohl seem to be the most undecided. Do what you can to help them make up their minds.❖



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American Heart Association

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Letters
WMJ article on surgeons and HIV prompts concern

To the editor: The Midwest AIDS Training and Education Center (MATEC)-Wisconsin provides educational programs for health professionals, to improve their skills and confidence in caring for HIV-infected clients and their families. We are generally supportive of efforts to improve physicians' understanding of the issues that surround HIV-related care.

We have reviewed Dr Donald H. Kranendonk's article on "Surgeon needle sticks, and HIV" (*Wis Med J.1994;93(3):109-113*). We are concerned because the article leaves the reader with the impression that physicians are at much higher risk of HIV infection than has been borne out by more than 10 years of experience with the epidemic.

- Dr Kranendonk's article states that the "cumulative risk of HIV infection for the average surgeon now ranges from 1 in 5 to 1 in 100," which suggests that many Wisconsin physicians could expect to be infected each year. In fact, the CDC has documented only five cases nationally--in 10 years--of physicians who seroconverted following occupational exposure.
- In several instances, Dr Kranendonk quotes rates of risk that are not substantiated by experience. For example, the article states that "the annual rate of medical interns becoming infected with the AIDS virus due to percutaneous puncture is 1 in 1,000." In view of the fact that there are more than 60,000 house officers nationally at all times, this contention is incompatible with the data cited above.

Health care workers' overall risk of occupationally acquired life threatening infection includes the risks from exposure to hepatitis, HIV, multiple drug resistant tuberculosis, and several other major pathogens. We believe that the wisest and most effective way to protect health care workers from occupational exposure to these and other pathogens is through the use of well monitored universal precautions. For health care workers who are specifically interested in reducing their risk of HIV infection, the most important steps are still in the realm of off-the-job behavior: avoiding unsafe sexual practices and unsafe drug use.

--Charles E. Gessert, MD
Site Coordinator, MATEC
--Terrance G. Brennam, MPH
Program Director, MATEC❖

Physician petition leads to changes at WIPRO

To the editor: Earlier this year a petition circulated throughout Wisconsin called into question the quality of peer review performed by the Wisconsin Peer Review Organization (WIPRO). More specifically the document expressed concern over the credentials of WIPRO's physician reviewers and the tendency of the review to encourage physicians to perform unnecessary diagnostic and other procedures. Hundreds of Wisconsin physicians signed the petition to witness their agreement with its call for a vote of no confidence in WIPRO.

Recently, officials from WIPRO met with the author of the petition in an effort to better understand the issues and to look for suggestions for improvement. The representatives from WIPRO agreed with several of the issues contained in the petition, but rather than debate the particulars all of the participants agreed to discuss areas of common ground and to form the basis for a constructive future. As a result of the meeting, two major themes emerged which will, we believe, go a long way toward making improvements in the system and meeting the concerns in the petition.

First, WIPRO has modified or enhanced several programs to ensure high quality peer review. Physician reviewers are credentialed in much the same way they would be when joining a hospital staff. New methods of recording and delineating the results of peer review have been adopted to reduce variation in physician response. And an internal quality assurance (IQA) program headed by a physician committee oversees the credentialing and review process, even re-reviewing cases to verify the quality of review

Continued from preceding page
decisions. Occasionally the IQA process results in the discontinuation of a reviewer whose work is found wanting.

Second, a national movement has begun within that will greatly reduce the amount of individual record review being done and replace it with quality improvement projects. Dubbed the Health Care Quality Improvement Program this new initiative emphasizes data collection and analysis of patterns of process and outcomes across larger numbers of patients in a cooperative manner. By its very nature this movement away from individual chart review avoids attention to minutiae and searches for variations which, when evaluated, may provide opportunities for improvements in patient care. The rise of this emphasis in WIPRO's work will greatly reduce the likelihood of antagonistic encounters which, while not at all unique in Wisconsin, have plagued practicing physicians and WIPRO staff alike.

We at WIPRO trust that these changes will go a long way toward meeting the concerns in the petition. We thank the author for his concern and energies and invite the comments and suggestions of any others who have an interest in improving the process of review as we all strive to improve patient care.

--John J. Kief, MD
President, WIPRO
--Greg E. Simmons
Chief Executive Officer, WIPRO❖

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PROSERVICES

Joy is the only perfection

To the editor: Allow me to comment on an article in the June 1994 *WMJ* by Maigaard and Schiedermeyer, "Clarifying goals, improving communication, and finding joy in the doctor-patient relationship."

Thank you for another amusing anecdote illustrating America's obsession with denying death.

The case of Mrs X was--again--an example of an undiagnosed and thus untreated psychiatric condition. If Mrs X refuses to return to a psychiatrist (this was left unclear) then non-psychiatric doctors would need to acquire the skills and take the time necessary to obtain a thorough personal history. This would yield the key to Mrs X's anxiety, presumed somatization disorder, and possible personality disorder. It would give the conscientious and capable therapist the tools to work with her and some chance that she would improve.

I said "take the time." Too many of us are ruled by "time is money," hardly a great humanistic maxim. American doctors' socioeconomic rank has risen from solidly middle-class before World War II to upper middle class or upper class since World War II.[1] Far more prospective medical students are interested in lifestyle rather than in joy, we know that. Most of my colleagues decline to work with Medicaid patients, not because their psychodynamics are insufficiently challenging (they are!) but because it doesn't pay. Recently a most amiable general practitioner said to me as I was trying to re-refer a patient, "I don't make a living listening to those folks, I make a living getting them out of my office as fast as I can. It's the system." System indeed. I fail to see how joy and haste can be very compatible.

Should our system change to a single-payer plan as is the case of all so-called civilized countries, the same bell-shaped distribution of talent, enthusiasm, and joy will prevail among doctors. In fact, after awhile, one could expect that the curve might move slightly to the right, meaning more of us would like what we do, not fewer. And if a number of potential medical school candidates switch to more lucrative fields to be guaranteed a Mercedes Benz within a few years of graduating (I'm not sure what those fields could be), the public will have suffered no irreparable loss in my opinion.

May I recommend the following classic: "Taking Care of the Hateful Patient," by James E. Groves, MD.[2] It is brilliant and hilarious, and could usefully be required reading once a year or more. It will recharge your batteries, relieve unwarranted guilt, help avoid excessive counter-transference hate, and restore joy if only for awhile. As Spinoza said, "joy is the only perfection."

--Victoria Lewin-Fetter, MD
Milwaukee

1. Altman D. Personal communication. Robert Wood Johnston Foundation, Princeton, NJ. 08540
2. Groves J. Taking Care of the Hateful Patient. *N Eng J Med.*1978;298:883-887.❖

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Newborn screening for cystic fibrosis in Wisconsin: first application of population-based molecular genetics testing

Philip M. Farrell, MD, PhD; Richard A. Aronson, MD, MPH; Gary Hoffman, MS; and Ronald H. Laessig, PhD, Madison

Infants born in Wisconsin are being screened for cystic fibrosis (CF) associated with the F508 mutation. This screening program has been developed during 9 years of research supported by the National Institutes of Health and involves a unique, two-tier system employing measurement of immunoreactive trypsinogen (IRT) initially. When the IRT level is high, DNA is extracted from the neonatal dried blood specimen and analyzed for the F508 mutant allele, following polymerase chain reaction (PCR) amplification; the F508 mutation is present in more than 90% of CF patients and accounts for the common, severe form of the disease. Infants with a positive DNA test are either CF heterozygote carriers or CF patients, depending on the results of a sweat test, which should be performed at 4 weeks of age. Screening the newborn population for CF provides the opportunity for early nutritional and respiratory interventions, as well as genetic counseling. This represents the first population-based application of molecular genetics for detection of a major congenital disorder causing serious public health problems. The process by which the recommendation was reached to screen for CF is described in this article, along with new information on the pathogenesis of CF, its clinical presentation, the rationale for newborn screening, and the method developed for the screenmg program. *Wis Med J.1994;93(8):415-421.*

Screening has been defined as "the application of a test to people who are as yet asymptomatic for the purpose of classifying them with respect to their likelihood of having a particular disease."[1] The screening procedure itself does not generally diagnose illness, but rather those who test positive are sent for further evaluation by a subsequent diagnostic test or procedure to determine whether they do in fact have the disease.[1]

Newborn screening can be described as a population-based public health program applied regionally to reduce the morbidity, severity, or mortality of certain biochemical genetic disorders, using dried blood specimens from newborns analyzed in centralized laboratories linked to clinical follow-up systems for presymptomatic detection and diagnosis. Generally, newborn screening tests lead to the presumptive identification of unrecognized disease to allow for therapeutic interventions with a variety of goals such as prevention of mental retardation and developmental disabilities in children with phenylketonuria (PKU).

In addition to PKU, the prototype disorder for newborn screening, other tests currently used in Wisconsin detect congenital hypothyroidism, galactosemia, biotinidase deficiency, congenital adrenal hyperplasia, and hemoglobinopathies such as sickle cell disease.

As a result of a 9-year, statewide research project and nearly 1 year of a systematic review and approval process, CF is a recommended addition to Wisconsin's newborn screening program. A unique, two-tier test is being employed for this purpose involving initial measurement of im-

From the Newborn Screening Advisory Group and its Molecular Subcommittee, Division of Health, Department of Health and Social Services. Reprint requests to: Philip M. Farrell, MD, PhD, University of Wisconsin, 600 Highland Ave, Madison, WI 53792-4108. Copyright 1994 by the State Medical Society of Wisconsin.

munoreactive trypsinogen (IRT) followed by DNA extraction and analysis for the most common CF mutation, namely the F508 allele.

Epidemiology, pathogenesis, treatment

CF is an autosomal recessive disorder that occurs with a relative incidence rate of 1 CF patient in 4,000 newborns.[2] CF was recognized and described as a distinct clinical entity in 1938, but the pathogenesis of this disease has been clarified during the current decade.

Originally, the pancreatic abnormality was considered the primary lesion. Subsequent research by di Sant'Agnese revealed characteristically abnormal sweat electrolyte concentrations, which established the concept that the disease is a generalized disorder of ion transport.[3] On the basis of molecular genetics research,[4] CF fundamentally can be attributed to mutations occurring in the long arm of chromosome 7. With cloning of the CF gene in 1989, it was determined that the most common mutation is a three base pair deletion, referred to as the F508 allele, and resulting in the loss of phenylalanine at amino acid position 508 of the predicted gene product, namely the CF transmembrane regulator (CFTR).[4,5]

The abnormal CFTR protein is now considered the underlying pathogenic factor in the disease process due to its putative role in regulating ion transport across the apical membrane of epithelial cells, particularly chloride conductance which is defective in CF.[6,7] The most recent research suggests that CFTR is the major structural component of the chloride channel, and that it regulates chloride transport by cyclic AMP-dependent process.[7] There are three categories of major abnormalities in CF: pancreatic exocrine insufficiency leading to malabsorption and malnutrition; chronic obstructive pulmonary disease with recurrent bronchopneumonia caused by unusual respiratory pathogens such as Pseudomonas aeruginosa; and salt loss in sweat that can lead to severe, potentially fatal hyponatremic dehydration.

The pancreatic disturbance begins prenatally and can cause intestinal obstruction in newborns with CF who have meconium ileus. In contrast, the lungs of CF patients are histologically normal at birth, but

Table 1.--Comparison of CF to the five addition and deletion criteria

Criterion 1	Incidence	At least 1 case per 100,000 births
	CF	° 1 per 4,000-5,000 births[6,15]
Criterion 2	Morbidity and mortality	Early detection benefits outweigh adverse consequences (false-positives, costs, etc)
	CF	° False-positives--significantly decreased using IRT/DNA protocol ° Other potential risks not apparent during study ° Scientific evidence for benefits accumulating - Favorable short-term studies in Australia, Great Britain, and Denmark[10] - Malnutrition and lung disease can be detected in asymptomatic, 2-month-old CF patients[18,19] - Northeastern Italian investigation revealing significantly better outcomes for screened patients[20]
Criterion 3	Potential for successful treatment	Effective management can be implemented to benefit infants
	CF	° Malnutrition can be prevented at CF centers[17] ° Improved respiratory therapy readily available ° Gene therapy to potentially "cure" lung disease being developed
Criterion 4	Costs	Cost of test must be comparable to that of other established tests
	CF	° Add-on cost estimated in Wisconsin is $3-3.50 per newborn ° Average cost/disorder currently being screened for is approximately $3
Criterion 5	Laboratory feasibility	Methodology must be adaptable to mass screening
	CF	° IRT/DNA methodologies can be effectively added to routine screening, including mutation and multimutation analyses

recent research has shown evidence of pulmonary dysfunction by 2 months of age.[8] Despite being normal at birth, the CF lung inevitably and ultimately shows both obstruction and infection in all patients, although the onset and rate of progression of this problem vary widely among individuals.[6]

The diagnosis of CF is customarily made because of: a positive family history, which occurs in about 10% of cases;[9] the occurrence of meconium ileus; or as a result of intestinal malabsorption or chronic pulmonary obstructive disease. Once the characteristic signs and symptoms become evident, the diagnosis of CF can be established by performing a sweat test using quantitative pilocarpine iontophoresis.

Unfortunately, the diagnosis of CF is often delayed. Data available from the US Cystic Fibrosis Foundation's Patient Registry shown in the accompanying figure indicate that the mean age in 1992 was 4 years and the median 1.1 years. Some studies suggest that delay in diagnosis is associated with worse disease, including severe malnutrition and irreversible pulmonary infections;[9,10] in fact, approximately 40% of newly diagnosed patients in the United States have "failure to thrive/malnutrition."[9] Other observations, however, do not support a relationship between age of diagnosis and prognosis.[11]

Clinical management of CF involves treatment programs with three principal objectives: improve nutritional status; promote clearance of respiratory secretions; and control bronchopulmonary infections.[6] In addition, attention must also be given to managing gastrointestinal complications of CF, replacing excessive salt losses, and promoting psychosocial development.[6] These therapeutic interventions are highly specialized, complex, and difficult to maintain. Consequently, care programs for CF patients in the United States are organized in a network of more than 100 accredited CF centers operating according to criteria specified by the national Cystic Fibrosis Foundation. These centers have placed particular emphasis on enhancing nutrition (by pancreatic enzyme therapy and vitamin supplements) and using aggressive strategies to prevent progressive pulmonary disease (by promoting clearance of respiratory secretions and administration of antimicrobial agents).

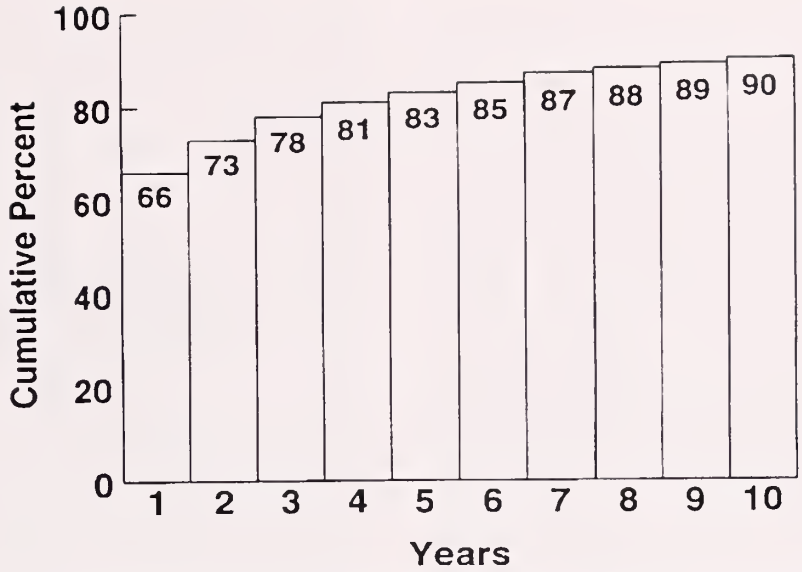

Fig.--Age at diagnosis for 885 CF patients diagnosed in the United States during 1992. (Courtesy of the Cystic Fibrosis Foundation Patient Registry, as provided by Dr Stacey FitzSimmons.)

Although CF lung disease cannot be cured, these comprehensive treatment programs have generally been effective, as evidenced by the increasing longevity of patients in the United States from a median survival of less than 20 years to approximately 30 years during the period of 1978 to 1992.[9]

Neonatal screening

On the basis of retrospective analysis of outcomes related to age of diagnosis, Shwachman et al[12] recommended newborn screening for CF in 1970. The first attempts made to identify CF through screening used qualitative analysis of albumin in meconium at bedside, but the validity of this procedure was uncertain and experience[6] was discouraging.

The possibility of newborn screening became more hopeful in 1979 when Crossley et al[13] applied measurement of IRT to neonatal dried blood specimens collected on Guthrie cards in New Zealand. They demonstrated that the IRT test could be applied successfully to such specimens, thereby allowing screening in centralized laboratories. Subsequent experience in other countries was encouraging. In the United States, however, the Cystic Fibrosis Foundation recommended caution and more research, including critical assessment of the IRT test per se and study of the value of early treatment related to prognosis; these recommendations were published in 1983 after a task force review.[14]

A prospective, controlled investigation of CF neonatal screening was planned in 1984 and initiated in 1985 as a statewide collaborative research project involving the Madison and Milwaukee CF centers affiliated with the University of Wisconsin and the Medical College of Wisconsin Departments of Pediat-

rics, respectively, the state Laboratory of Hygiene's Newborn Screening Program, and primary care physicians who generously cooperated throughout Wisconsin. The ensuing study represents the largest prospective pediatric research project since the polio vaccine field trials of 1954. As a result of 9 years of investigation, involving 650,341 newborns in the screened and control ("standard diagnosis") groups, an excellent test has been developed and its validity rigorously assessed, along with benefits and potential risks to children and their families involved in the screening program.

The new test, referred to as the IRT/DNA method, represents the first application of molecular diagnostic technology in a population-based fashion. The method involves an initial measurement of IRT, on a punched disk from the neonatal dried blood specimen. IRT levels are increased in the blood of newborns with CF because of their obstructed pancreatic ductules. When the IRT level is high, the second-tier test is performed on DNA extracted from another punched disk of the same blood specimen which is analyzed after PCR amplification for the major CF mutation (the F508 allele), as described by Gregg et al.[15]

The IRT/DNA test

During the 9 years of research, two screening protocols were used. The original protocol, from April 1985 through June 1991, analyzed blood spot specimens with a radioimmunoassay for IRT, and a level of $\geq$180 ng/mL was used to identify those newborns who needed a sweat chloride test for diagnosis of CF.

There were 220,862 newborns screened by 4 weeks of age during this period, of which 369 had initially elevated IRT levels. Repeat IRT measurements at the time of sweat tests when the babies were generally 4 to 8 weeks old showed that decreases in IRT level limited the utility of "recall" tests as employed for other newborn screening tests. Sweat testing confirmed 46 cases of CF. There were 7 "missed cases" of CF due to IRT levels less than 180 ng/mL (3 were diagnosed at birth because of meconium ileus, and the other 4 showed symptoms of CF). The sensitivity, specificity, and positive predictive value (PPV) were 86.7%, 99.9%, and 12.5%, respectively.

The second protocol, from July 1991 through December 1993, applied an innovative two-tier method involving the IRT assay with a lower cut-off of 110 ng/mL (approximately the 99th percentile) to identify samples to be further assessed for the presence of the F508 mutation by DNA analysis. Newborns with DNA test results revealing one or two F508 mutations were then referred for sweat testing. The lower cut-off value was selected to avoid "missed cases."

In this protocol, 94,259 newborns were screened, of which 1,746 were referred for DNA mutation analysis. There were 106 positive DNA analyses, of which 18 had positive sweat tests. To date, no known CF cases have been missed with this protocol during the July 1991 thtough December 1993 screening period. The sensitivity, specificity, and PPV were 100%, 99.9%, and 17%, respectively.

Comparing the two protocols, it is evident that with using the two-tiered IRT/DNA protocol the number of newborns referred for follow-up (mutation analysis) can be increased, therefore, reducing false-negative concerns and simultaneously decreasing the number of sweat tests needed to detect CF. For example, there were 214 IRT results above 180 ng/mL during the IRT/DNA protocol period that would have led to sweat tests had the DNA assay not been available. With DNA testing available, only 106 sweat tests were needed.

Review and approval process

To determine if newborn screening tests such as the one for congenital adrenal hyperplasia implemented in 1993[16] or for CF should be added to the panel, an extensive, critical review process has been used. This process began in 1990 when the secretary of Health and Social Services established a Newborn Screening Advisory Group for "periodic review and evaluation of Wisconsin's neonatal screening program."

This group has been administered by the Division of Health, Department of Health and Social Services. It was constituted with experts in newborn care and screening from around Wisconsin and was charged with the following responsibilities: review the state's screening program annually; propose reporting and tracking protocols; and recommend tests for addition to or deletion from the panel. To address panel revisions, an addition and deletion subcommittee was appointed, and this group developed the following recommendations and criteria.

"In general, screening should not take place unless the disorder is recognized as an important public health problem for which there will be a commitment of financial support. Benefits to identified infants should outweigh the costs of the screening program." Specific criteria include:

- "Incidence: The identification of 1 case per 100,000 births should be the minimum number for any specific disorder. With an annual birth rate of 70,000-75,000, Wisconsin should expect to identify approximately 1 case per year.
- "Morbidity and Mortality: Assessment of scientific evidence should support the expectation that benefits of identification in the neonatal period (treatment effective only when started before the age at which clinical diagnosis is usually made) will outweigh adverse consequences

Table 2.--Wisconsin Neonatal Screening Results During 1991 and 1992.*

	Phenylketonuria	Congenital hypothyroidism	Galactosemia
Positive test results	67	600	148
Follow-up positive results	20	41	29
Confirmed cases	5	31	2
Sensitivity (expected %)	100	100	100
Specificity (%)	99.9	99.5	99.3
Positive predictive value (%)	6.9	5.2	1.4
Follow-up test predictive value (%)	25	43	6.5
Relative incidence rate**	1:28,100	1:4,500	1:70,300

* Data shown are for 1991 and 1992, during which time a total of 140,539 initial dried blood specimens were analyzed by the Wisconsin State Laboratory of Hygiene.
**Incidence calculation assumes one newborn per initial sample.

- "Potential for Successful Treatment: There should be evidence that effective management can be implemented to benefit infants and their families; diagnosis without effective treatment is inappropnate.
- "Cost: Laboratory costs of any test to be added should be comparable to the costs of well-established tests such as PKU."
- "Laboratory Feasibility: Test must be adaptable to a mass screening program. The health care system and laboratory technology limits tests to those that use blood specimens at this time."

These criteria were approved by the Division of Health, following which decisions were reached about adding congenital adrenal hyperplasia testing and deleting maple syrup urine disease and homocystinuria. In October 1993, following 3 months of review--which included expert, independent advisors (see acknowledgements)--the subcommittee approved addition of CF testing with the IRT/DNA method. The following month, the Newborn Screening Advisory Group unanimously recommended CF testing for subsequent approval by the Division of Health.

Rationale for routine screening

Two considerations were investigated by the Newborn Screening Advisory Group to determine whether CF should be considered for routine screening. The first consideration was to apply the observations from the Wisconsin CF Neonatal Screening Project and other research findings to the criteria that were developed in 1992 to determine which congenital disorders should be screened for in Wisconsin. This analysis is summarized in Table 1. The comparison led to a conclusion that CF substantially meets all five criteria.

The second consideration was to compare the calculated sensitivity, specificity, and positive predictive value to that of the other established disorders currently screened for in Wisconsin such as PKU, congenital hypothyroidism, and galactosemia. Results shown in Table 2 indicate that CF compares very favorably.

In fact, analysis of the initial dried blood specimen with the IRT/DNA test is associated with the highest positive predictive value for disease diagnosis. Moreover, infants with the F508 mutation and a negative sweat test are CF heterozygote carriers, and thus, their families are able to receive genetic counseling.

The comprehensive analyses performed clearly support adding CF screening to the newbom screening panel. There is increasing evidence that a favorable risk-benefit relationship occurs when infants are identified early through screening and are provided with appropriate nutritional and respiratory care.[17] Consequently, routine screening for CF has been initiated on babies born after June 1994. The goals of this screening program are listed in Table 3 and emphasize prevention of adverse consequences of CF that often begin during early infancy.

It should be mentioned that the routine program will be using an even lower IRT cut-off (initially 56 ng/mL, which is approximately the 96th percentile). The decision to use this IRT level was made by the Division of Health Molecular Subcommittee based on three considerations: a change in the IRT methodology and assay kit has occurred from the Sorin radioimmunoassay to the DELFIA fluoroimmunometric procedure; experience in the CF Neonatal Screening Project suggests that avoiding "missed cases" can best be achieved with a lower IRT cut-off, and the molecular subcommittee was especially sensitive to this during the initiation phase of routine CF screening; and using the 96th percentile IRT cut-off generates 80 speci-

mens per week for DNA (F508) analyses—a number that can be conveniently processed with PCR technology.

Notifications

As a result of IRT and DNA results, there will be five categories of reports issued. The first will be a normal, low-level of immunoreactive trypsinogen for which no action is required; approximately 96% of test results will be in this category.

The second type of report pertains to trypsinogen levels between 56 and 170 ng/mL followed by DNA analyses resulting in no F508 mutant alleles detected; this is a second category of negative report.

When the trypsinogen level is quite high, ie, greater than 170 ng/mL, and no F508 mutant alleles are detected, the report will specify the following: "This trypsinogen level may be indicative of cystic fibrosis." The molecular subcommittee for newborn screening recommends: be alert to signs of CF which may include persistent diarrhea, poor weight gain, chronic cough, or respiratory problems; if these signs appear of if there is a family history of CF contact one of the CF specialists to discuss indications for sweat tests. This third category constitutes an alert to the primary care physician and CF centers that there is a very remote possibility of the disease, but there is no need to obtain a sweat test unless signs of CF appear or the family history is positive. We anticipate that 1 or 2 patients per year could be in this category of non-F508 CF, although they could present earlier with meconium ileus or other signs and symptoms.

When the trypsinogen level is greater than 56 and the DNA analysis is positive for F508, the report will indicate that the presence of one F508 allele is "suggestive of cystic fibrosis," and it will recommend that the baby have a quantitative pilocarpine sweat chloride test at 4 weeks of age.

The final category, reported on a gold form, will be for infants who have a trypsinogen level greater than 56 and two F508 mutant alleles detected. The report will state that "the presence of two F508 mutant alleles is consistent with the diagnosis of cystic fibrosis (CF). The molecular subcommittee for newborn screening recommends a quantitative pilocarpine sweat chloride test at four weeks of age to confirm the diagnosis of CF. To prevent a missed diagnosis, the sweat test should be performed in a Cystic Fibrosis Foundation-certified center experienced in sweat testing infants."

In this category, the screening test can actually allow diagnosis of CF patients by 2 weeks of age directly from the dried blood specimen. This is a special situation in which the screening test becomes a diagnostic test. We anticipate approximately 10 CF patients per year will be diagnosed as homozygous for the F508 mutation, whereas 5 to 10 patients will be identified because of having one F508 allele and a high trypsinogen level.

Newborns with CF who have meconium ileus at birth, however, occasionally have IRT levels that could cause a false-negative result to occur with the first-tier test. If sample collection personnel routinely note meconium ileus on the collection form from these newborns, CF mutation analysis will be performed. Forms provided by the state Laboratory of Hygiene later this summer will contain a meconium ileus check-off item.

As in current clinical practice, physicians who strongly suspect CF should obtain a quantitative sweat test irrespective of the neonatal screening result. Consequently, if meconium ileus occurs or if there is a positive family history of CF, it is essential to use the diagnostic test when the baby can produce adequate sweat (generally 2 to 6 weeks of age), rather than relying on the IRT/DNA result for diagnosis. The same caution applies to all neonatal screening tests since no laboratory procedure and notification system should be regarded as infallible.

Table 3.--Goals of newborn screening for CF.

1. Initiate CF center-based care in the neonatal period
2. Provide genetic counseling
3. Prevent severe malnutrition
   - vitamin E deficiency (hemolytic anemia)*
   - vitamin A deficiency
   - essential fatty acid deficiency
   - protein energy malnutrition*
   - growth failure
4. Prevent hyponatremia and hypochloremia*
   - salt loss in sweat
   - associated with breastfeeding
5. Prevent early progression of lung disease
   - recurrent bacterial infections
   - obstructive pulmonary disease
   - atelectasis with mucus plugs

*Potentially fatal

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Outpatient vaginal hysterectomy in a community hospital

Matthew A. Meyer, MD; Roger A. Lalich, DO; Margaret M. Meyer, RNC, MS; and Judy Widener, RN, Waukesha

From Sept 1, 1992 to Dec 31, 1993, 38 outpatient vaginal hysterectomy patients were evaluated for identification of complications after discharge, adequacy of pain relief at home, return to baseline lifestyle, and costs. No complications that would have necessitated an overnight or longer stay were identified. All patients reported adequate pain relief and a more rapid return to activity than they had expected. The hospital cost of outpatient vaginal hysterectomy was about half that of inpatient, and additional significant savings were realized in the cost of postoperative medication. Patients were positive about returning home the day of surgery and would recommend the protocol to others who qualified. *Wis Med J.1994;93(8):x-x.*

TRADITIONALLY, vaginal hysterectomy patients have been hospitalized for several days after surgery to observe for complications and to manage pain. The most frequently encountered complications are hemorrhage and injury to the bladder, usually apparent immediately or within a few hours after surgery.[1,2] Infection may or may not exhibit symptoms during the hospital stay.

Despite the best of intentions, effective pain management in the hospital are too often confounded by staffing levels, availability of equipment and supplies, pharmacy distribution issues, varying interpretation of physicians' orders, the patient's subjective expression of her pain, and the way the nursing staff interprets that expression of pain.

Patient activities such as voiding attempts, walking, what and when to eat, receiving visitors, bathing, and sleeping tend to follow staff availability and hospital routines instead of patient preference and tolerance. Most people are used to independence and personal control over their activities, and are eager for a rapid return to familiar surroundings and routines.

It was these considerations that led us to evaluate a protocol for outpatient vaginal hysterectomy for our patients in a community hospital-based private practice.

This study of 38 outpatient vaginal hysterectomy patients was based on the reports of Stovall et al[3] and Powers et al,[4] but took place in a private practice, community hospital rather than a regional medical center or free standing outpatient surgery center.

After receiving approval of our protocol from the hospital institutional review board (IRB), we proceeded with our study. The questions we attempted to answer were:

- Will complications be identified and treated within a reasonable, safe time frame?
- Will patients tolerate outpatient major surgeries like total vaginal hysterectomy (TVH) as demonstrated by reporting acceptable pain relief and overall satisfaction ratings?
- How does a patient's preoperative expectation of the time necessary to return to baseline activities compare with her actual experienced time?
- How do the hospital costs of outpatient TVH compare with inpatient costs for the same procedure?

Methods

All patients who met standard criteria[5,6] for vaginal hysterectomy were asked to consider the outpatient procedure. Such criteria include rapidly growing and significantly sized fibroids, intractable menorrhagia and pelvic pain unresponsive to medical therapy, and pelvic relaxation.

The study group was composed of 51 patients who agreed to the proposed protocol. Each patient signed an informed consent approved by the IRB of the hospital.

The ages of the 51 patients ranged from 28 to 57, with a mean of 42.96 and a standard deviation (SD) of 6.58. The mean age of the 38 women who ultimately had the outpatient procedure was 42.58, with a range of 31 to 57, and a SD of 6.61.

Four of the 38 outpatients (10.5%) had never borne children; the highest number of children borne among the other 34 patients was four.

Nine (23.7%) listed their occupation as homemaker, four (10.5%) had moderately active jobs, and the other 65.8% did primarily sedentary, clerical-type work.

Indications for surgery included symptomatic pelvic relaxation, intractable pelvic pain and menorrhagia that failed conservative treatment, and significant fibroids. No one had medical contraindications to the surgery. Candidates were evaluated by history and physical examination to be free of adhesions, pelvic inflammatory disease, and endometriosis.[7] No patient was considered for vaginal hysterectomy or

From the Women's Health Care, S.C., in Waukesha. Reprint requests to: Matthew Meyer, MD, 426 W Main St, Waukesha, WI 53186. Copyright 1994 by the State Medical Society of Wisconsin.

laparoscopic assisted vaginal hysterectomy (LAVH) if the estimated operative time would exceed 90 to 120 minutes.

Candidates for outpatient hysterectomy were given extensive instructions by the physicians and by office-based registered nurses who made the postoperative house calls on the protocol requirements. Patients were expected to have an adult care-giver in the home with them for the first 24 to 48 hours after surgery.

Patients were instructed on walking, coughing and deep breathing, gastrointestinal function and diet restriction, oral fluid requirements, medication administration, and the signs and symptoms of problems requiring immediate notification of the physician. These problems included fever higher than 101°F, acute vaginal bleeding, severe pain, or intractable nausea and vomiting. In appropriate cases, suprapubic catheter management was presented. All teaching was reinforced with detailed written information for the patient and her home care-giver.

Patients were routinely scheduled for surgery at 7:30 AM and were prepared in the day surgery unit. Prophylactic antibiotics were administered as soon as the intravenous infusion line was placed. All patients received general anesthesia due to physician preference.

The early starting time was important to allow an adequate observation period in the day surgery unit before the patient was discharged. After surgery and routine recovery room care, each patient had a day surgery nurse dedicated to her progress toward discharge. Having the patient sitting up within 90 minutes, and walking within 3 hours, were the goals.

A fluid load of 3 liters of Ringer's Lactate solution was given within 3 hours of the start of surgery, with liberal oral fluids given in the day surgery unit. Hemoglobin and hematocrit levels were checked 1 hour after the intravenous fluids, and again at 4 PM. The protocol was met if there was a decrease of 10% or less between the two samples.

Hospital time (hours).

Time	Operating room	1st stage recovery	Day surgery recovery
Longest	2.5	2.1	9.1
Shortest	0.4	0.9	4.5
Average	1.4	1.3	7.1

The physician visited each patient several times during her day surgery stay. Close physician surveillance was essential to monitor subtle changes in the patient's course, to consult with staff, and to provide patient reassurance.

Each patient was catheterized at the conclusion of her procedure to assess urine concentration and volume. No indwelling catheter was placed unless there was a repair during surgery for which suprapubic drainage was required.

Bethanechol hydrochloride 25 mg was given orally twice during the day surgery stay and four times daily for the next two days to enhance bladder tone and to assure successful voiding. If a patient was unable to void prior to discharge, there was a standing order for her to return to the emergency department to be catheterized. Only one patient needed this service for a single catheterization. The nurse visiting the home was prepared to catheterize patients in the morning if necessary. No patient required catheterization at home. One of the advantages of working in a community hospital was the level of acceptance by patients and hospital personnel of the order to return for catheterization if needed.

Critical to successful pain management was vigorous, timely administration of analgesics. Intraoperative local anesthesia was applied using 0.25% bupivacaine solution, with a total of 10 mL in each uterosacral pedicle. This was applied prior to the peritoneum closure in simple vaginal hysterectomies and directly with a 5 mm. 21 gauge injection cannula at the time of "last look" in LAVH cases. Morphine, 2 mg IV, was given immediately postoperatively, and as needed for the first 3 hours. This was used as often as 30 minutes and as infrequently as 6 hours between doses.

Starting in the day surgery unit, each patient was given ketorolac tromethamine 10 mg orally and promethazine hydrochloride 50 mg rectal suppositories every 4 hours, continuing for 36 to 48 hours following surgery.

Promethazine hydrochloride was given to decrease postoperative nausea and to make the oral analgesia more effective. An oxycodone with acetaminophen tablet could be taken 1 to 3 hours after the ketorolac tromethamine and promethazine hydrochloride as necessary.

Preoperative teaching emphasized the importance of administering the analgesics as ordered for the first 24 to 48 hours, and then evaluating the need for pain relief on an individual basis.

Patients received a discharge prescription for trimethobenzamide hydrochloride 200 mg rectal suppositories for severe nausea. These were rarely needed. Those patients with a tendency toward constipation were advised to have stool softeners or suppositories available and to use them as needed.

Each patient received one or two home visits within the first 48 hours.

Oral temperatures, taken and recorded by the patient every 4 hours for 2 days, were reviewed. The nurse assessed the patient's lungs, blood pressure, pulse, intestinal tract function and signs of gastrointestinal distention. A blood sample for a CBC count with differential was drawn on each visit.

Postoperative instructions regarding walking, advancing diet, and medications were reinforced with the patient and her home caregiver. Questions about bleeding, urinary function, pain relief, and hormone replacement therapy were discussed. The patient also received telephone contact from the physician the day of surgery and the following two days, once the CBC had been assessed and the findings of the nurse reported and discussed.

Patients who had oophorectomy started estrogen replacement on postoperative day 1. The home visit afforded an opportunity for the nurse to discuss hormone replacement therapy at a time when the patient was receptive to the information, since the stress of anticipating surgery was over. All patients were seen in the office at 2 and 6 weeks postoperatively.

Each patient was called by a member of the office staff at about 6 weeks after her surgery and questioned about her recovery. A written questionnaire similar to that of Stovall et al,[3] addressing a number of aspects of the protocol was completed and mailed back by patients who had outpatient surgery.

Results

Of the 51 patients who elected to participate in the outpatient hysterectomy protocol, 38 (74.5%) were discharged the day of surgery.

Of the 13 patients (25.5%) who were admitted, nine were discharged within 24 hours. Three of the 13 patients were hospitalized because their hemoglobin and hematocrit levels decreased more than the 10% limit in the protocol. Two patients were admitted for severe nausea, two for severe pain, one for excessively deep sedation, and one for inability to void before discharge. All these patients were among the first 15 candidates.

Four of the 51 patients (7.8%) were admitted for laparotomy, three of them for severe endometriosis and adhesions, and the other for hemorrhage requiring laparotomy within 6 hours postoperatively.

Standard vaginal hysterectomies were sufficient for 33 of the 38 outpatients (86.8%). LAVH was used with five (13.2%). Fourteen (36.8%) had a BSO, one patient had an anterior repair, and one patient had a Marshall-Marchetti-Krantz procedure. Uterine weight, as reported by the pathologist, ranged from 59.6 g to 730 g, with a mean of 167 g and a SD of 127.9.

For the 38 outpatients, total time from the surgery start time to discharge from day surgery ranged from 6.8 hours to 11.4 hours, with a mean of 9.88 hours, and a SD of 1.12. The mean total length of stay for a similar group of inpatients was 56 hours. Operating room time ranged from 0.4 hours to 2.5 hours, with a mean of 1.44 hours and a SD of 0.5. LAVH cases took a mean time of 1.8 hours,and TVH cases took a mean time of 1.4 hours. First stage recovery room time ranged from 0.9 to 2.1 hours, with a mean of 1.3 hours and a SD of 0.34. Time in the day surgery unit ranged from 4.5 to 9.1 hours, with a mean of 7.08 hours and a SD of 1.1 (Table).

The addition of BSO to the procedures actually resulted in less total operating room time in our group. The mean operating room time for TVH alone (n=21) was 1.4 hours, while TVH with BSO (n=12) took a mean time of 1.33 hours. One of the later patients also had a Marshall-Marchetti-Krantz procedure that resulted in 2.5 hours total surgery time. Mean time for the other 11 TVH-BSO cases was 1.23 hours. This is comparable to another investigator[8] who found that the additional time necessary for oophorectomy was 11 to 20 minutes, but frequently took less than 10 minutes. Only two LAVH cases in our group had BSO. Those cases took 1.4 hours and 2.4 hours. No valid conclusions can be drawn from so few cases.

Twenty-seven of the 38 outpatients completed follow up surveys for a response rate of 71%.

Patients rated their pain relief on the day of surgery at a mean score of 4.8 on a scale of 1 (very dissatisfied) to 5 (very satisfied). Pain relief during the week following surgery was rated 5. Prescription analgesics were used for 2 days after surgery by 53% of the patients, for 3 days by 27%, and for 4 days by 20%. They took prescription pain medication for a mean of 6.9 days, ranging from 2 to 42 days, with a SD of 11.2. This included one patient with a granuloma of the cuff who had additional surgery for debridement, and who took these medications for 6 weeks. If her data are excluded, the mean time for prescription medication was 3.7 days with a SD of 1.8. Non-prescription pain medication was used by most of the patients after they no longer felt they needed narcotics for a mean time of 3.5 days, with a range of 0 to 7 days, and a SD of 4.5.

Patients rated nausea control the evening of surgery at a score of 5, and also at 5 during the week following surgery. They rated physicians' phone calls and nurses' home visits at 5, with an overall satisfaction rating of 4.9. Only two factors were identified as causing dissatisfaction. One was the requirement to have some preoperative work done at the office and other procedures done at the hospital. The other was the admission process on the day of surgery. These were not related to the study protocol, and feedback was provided to the appropriate hospital departments for follow-up.

In response to asking whether the patients would recommend this protocol to others who would qual-

ify, all said yes. One patient said that because she came home so soon, her family did not recognize that she was recovering from a major surgical event and did not treat her as "sick."

The patients' actual return to routine sleep, eating, and activity was compared to their own preoperatively anticipated time of recovery. The mean actual return to normal activity was 10 days. The patients' perception of recovery time prior to their surgery was an average of 34 days. Actual return to work was not used as a measure of recovery. Most of the patients employed outside the home were entitled to take a specified amount of time off with sick or disability pay according to the procedure performed. They were reluctant to return to work sooner, regardless of how good they felt. This corresponds to the findings in a study of French and American laparoscopic cholecystectomy patients.[9]

The outpatient vaginal hysterectomy protocol lowered average hospital costs in our study by nearly half, the same ratio identified in another study.[4]

Discussion

We found that it was possible to monitor and manage complications of outpatients, to achieve adequate pain relief without parenteral analgesics, to return patients to their baseline lifestyle and activity levels earlier than they expected, and to achieve significantly lower hospital costs.

As demonstrated in this and other studies,[3,4,10] patients can be safely released from the hospital following outpatient hysterectomy. The discharge criteria of walking, voiding, acceptable hemoglobin and hematocrit levels, and ability to tolerate oral fluids were associated with continued satisfactoryprogress once at home. Giving specific oral and written instructions on expectations, medications, restrictions, and the required supervision were important adjuncts to patient safety and optimal physical response to the protocol. Personal monitoring by physician phone calls and home visits by nurses allowed direct assessment of the patient's status and opportunities for discussion of any problems.

There was one patient who required brief outpatient surgery for treatment of a granuloma of the vaginal cuff. She exhibited symptoms of low grade fever and pain on postoperative day 5, did not respond to oral antibiotics, and ultimately needed surgical debridement of the cuff and additional antibiotic therapy. Her problem, as it evolved, would not have appeared during the routine inpatient hospital stay, and was managed without significant problems following her discharge.

The addition of bethanechol hydrochloride tablets to the day surgery routine orders and discharge medications resulted in the elimination of voiding problems before and after discharge in our group. The patient who remained hospitalized over night for inability to void and the patient who returned to the emergency department for catheterization did not receive routine doses of bethanechol hydrochloride in day surgery. Bethanechol hydrochloride became part of the routine orders in response to these two situations.

It also appears to offer a significant advantage in pain management because of the timely initiation of analgesic agents and early activity, monitored closely by one-to-one, prolonged nursing care. Pain management in inpatients appears to have too many inherent distractions to afford timely pain control. The outpatient approach also results in more independence for patients and families by dealing with this common surgery in a more individual, personal manner. The survey scores confirmed the overall satisfaction of patients with the program.

This study adds to the findings of other studies that report the safety, efficacy, and cost savings of outpatient vaginal hysterectomy. Before adopting this type of program, each member of the physician team must honestly assess his or her level of competence. Each physician must be committed to empowering operating room staff, nursing personnel, and patients by imparting the philosophy, communication skills, education, and techniques of outpatient vaginal hysterectomy. Quality assurance of the expected outcomes of this surgery must be as rigorous and thorough as that for inpatient surgery.

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Mobitz Type II heart block presenting as weight loss

Charles E. Wirtz, MD, and John Hayes, MD, Marshfield

Weight loss in the elderly can be due to many different disease processes, most often neoplastic. We present a case of weight loss secondary to Mobitz Type II heart block in a patient with normal left ventricular function that was reversed with a permanent pacemaker implantation. Weight loss in the elderly is a common manifestation of many disease processes.[1,2] We present an unusual case of weight loss, malaise and dyspepsia that was completely reversed by pacemaker implantation for Mobitz Type II heart block. *Wis Med J.1994;93(8)x-x.*

Case report

The patient is a 72-year-old man who came to us in March 1993 after two days of mild cough, nasal pressure and congestion, low grade fever, and chills. He also stated that, over the several preceding months, he had developed early satiety, postprandial dyspepsia, and felt that he was losing weight. He said he had no nausea, vomiting, or any change in bowel habits, and reported no other systemic symptoms.

A physical examination demonstrated cachexia, but no acute distress. The patient's blood pressure was 130/79, pulse 80, and temperature of 99.9°. An examination of his neck demonstrated no jugular venous distension, but right carotid and bilateral subclavian bruits were present. The pulmonary examination revealed decreased breath sounds with generalized wheezing and crackles at the right base. A cardiovascular examination demonstrated good peripheral pulses. The heart rate was regular with no gallops, and a chronic 1/6 murmur of aortic stenosis was present. The findings of an abdominal examination were normal, and a rectal examination demonstrated a normal prostate with hemoccult-negative stool. A neurological examinatoin revealed no deficits.

An initial laboratory evaluation included room air arterial blood gases with a pH of 7.43, PC02 of 32, P02 of 57 and an 02 saturation of 91%.

X-ray films of the patient's chest demonstrated prior asbestos exposure with no new infiltrates, and sinus films demonstrated no mucosal thickening. Pulmonary function tests found a mild obstructive pattern with an FEV_1 of 1.99 L. A CBC count found a WBC of 8,700, hemoglobin level of 12.4 g/dL, and platelet count of 193,000. Results of the peripheral smear were unremarkable. Anemia evaluation demonstrated normal B_{12} and serum folate levels, and normal thyroid function. Results of iron studies were consistent with a chronic disease pattern. ANA and rheumatoid factors, obtained as part of a failure to thrive evaluation, were nonreactive.

The patient was treated with inhaled beta-antagonists and a corticosteroid metered dose inhaler, Bactrim DS one tablet by mouth twice daily, Entex LA one tablet by mouth twice daily and Famotidine 20 mg by mouth twice daily.

The patient continued losing weight, and lost 17 lb over 3 weeks. His postprandial dyspepsia and early satiety had been unchanged by H2 blocker therapy. He specifically denied any neurologic or cardiac symptoms. His breathing had improved with metered dose inhalers and antibiotics. A repeat CBC count at his return visit showed his

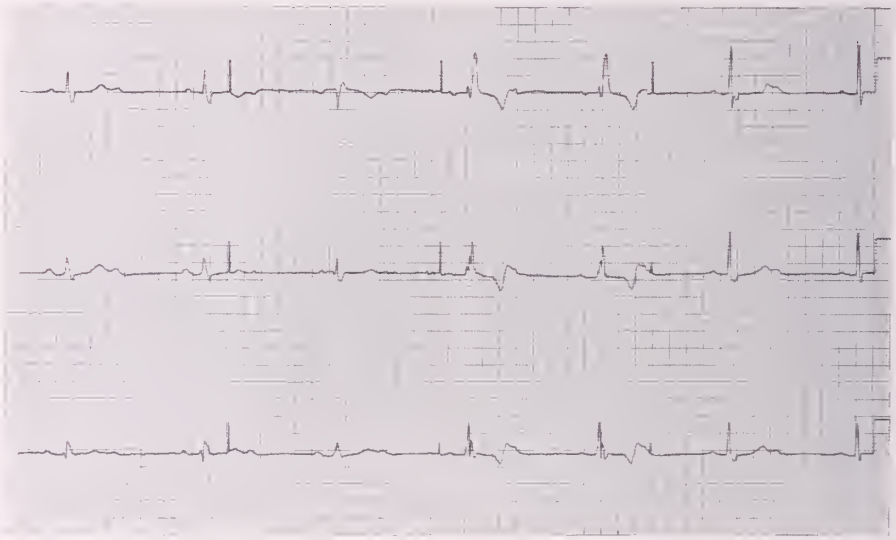

Fig.--ECG showing Mobitz II Heart Block.

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hemoglobin had increased to 14.4 g/dL. Arterial blood gases on room air on his return visit demonstrated a pH of 7.42, PC02 of 34, and P02 of 79. The findings of esophagogastroduodenoscopy and colonoscopy to the cecum were negative.

An electrocardiogram was ordered to evaluate a pulse of 48 as recorded during his follow-up evaluation and showed a Mobitz Type II second degree heart block. An echocardiogram was remarkable only for the evidence of the conduction block. A Lyme titer was nonreactive and serial cardiac enzymes were negative for infarction. A DDD **(note to author: please spell out DDD on first reference)** pacemaker was implanted 24 hours after admission.

The patient's symptoms completely abated 24 hours after pacemaker implantation, and within 6 weeks his weight returned and he had no further gastrointestinal (GI) complaints.

Comment

Mobitz Type II heart block accounts for about 25% of the permanent pacemakers placed in a recent large series[3] with the electrophysiologic mechanism being unclear, but representing infra-Hisian block in the cardiac conduction system.[4] Although there is controversy over the use of pacemakers in "asymptomatic" patients with Mobitz Type II heart block,[5] the electrophysiologist consulted felt the risk of progression was too great not to insert a permanent pacemaker.

Idiopathic symptoms of weight loss, dyspepsia, and malaise with negative standard metabolic and GI workup are akin to the pediatric diagnosis of failure to thrive, which is also being recognized as a geriatric diagnosis, and is most commonly due to dementia, depression, delirium, drugs, or physical illness.[1,2]

Marton, et al,[6] retrospectively evaluated 91 patients with involuntary weight loss, 19% were found to have various cancers, 14% with various GI disorders, and 9% with cardiovascular disease. All patient's with cardiovascular disease had New York Heart Class III to IV function or congestive heart failure.

Our patient did not have congestive heart failure, and actually reported New York Heart Class I function. Rabinovitz, et al,[7] in an inpatient series, found 36% of patients had various cancers, with the most common being GI cancer. He documented few, if any, cardiovascular causes of involuntary weight loss.

The postulated mechanism of failure to thrive in our case is felt to be mesenteric ischemia due to a combination of mesenteric vascular disease and decreased cardiac reserve secondary to Mobitz Type II heart block. We find it unusual to have GI symptoms predominate over classic cardiac or neurologic symptoms in the face of normal left ventricular function. Confirmation of our postulate is complete symptom reversal within hours of pacemaker implantation.

Summary

We present a case of a 72-year-old man with Mobitz Type II heart block whose symptoms were that of failure to thrive. It is postulated Mobitz Type II heart block, in combination with some degree of mesenteric vascular disease, caused failure to thrive, presumably because of decreased ability to optimize mesenteric perfusion to meet the postprandial demands of the GI system.

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Quality of care: Joining forces to define it

Norman W. Hoover, MD, Milwaukee

WHETHER HEALTH CARE costs too much--and most believe it does--the central question is: What constitutes good and appropriate medical care? If we can't prove that what we do is worth doing, we will have no defense against those who say it is too expensive. Prominent issues in the literature of change are: variation, uncertainty, and questionable practice patterns as problems; and continuous quality improvement (CQI), outcomes research, and practice guidelines as their supposed solutions.

Einstein is reported to have said: "The kind of thinking that got you into this mess isn't likely to get you out of it."

What works?

That poses what should be the central theme of reform of health care. It is also the title of Vibbert's[1] recent monograph, which examines the whole spectrum of the outcomes-guidelines movement.

Cost has dominated the debate about reform of health care, but only because we have allowed it to. No one can dispute that cost and quality need both to be addressed, but if cost forces the issue, quality may be at risk. On the other hand, one can make a strong case that high quality applied with careful attention to effectiveness may reduce cost. We need only to be sure we do just what works.

Previously unsuspected variation in practice patterns is now known to be widespread, but is not a new observation. Glover[2] noted in 1938 that there were great differences of tonsillectomy rates among populations of London and greater London: "An Enfield child is 20 times more likely to have the operation than one in Hornsey." There was tenfold difference in rates even between neighboring and apparently similar populations of primary school children, and with no apparent reason other than differing opinion about indication for the operation.

Other sporadic reports of practice variation have appeared, but the phenomenon has been though uncommon and idiosyncratic until Wennberg[3] made methodical population based studies in New England in the early 1970s. He found wide variation of almost everything to be the rule rather than the exception. For instance, the populations of New Haven and Boston are about equal in size and demographically similar, and both receive most of their hospital care in university hospitals. Still, Boston expended nearly twice as much per capita for hospital care. There were almost twice as many joint replacements and carotid endarterectomies done in Boston and twice as many coronary artery bypasses done in New Haven. Yet there was no demonstrable difference of either morbidity or mortality in the two populations. He concluded wryly: "academic standards of care are compatible with widely varying patterns of practice." The problem was clearly not one of incompetence or lack of learning.[4]

Later studies compared practices of salaried physicians in socialized societies with fee-for-service practices in free-market economies.[5] The types and degrees of variation were nearly identical. The problem seems not to be driven by financial incentive, but by honest difference of opinion.

When a wide variety of medical conditions were compared in Maine, including childhood respiratory illness, coronary artery occlusion, benign prostatic hypertrophy, low back pain and sciatica, carpal tunnel syndrome and benign uterine dis-

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ease, rates of treatment varied widely, often by four- to sixfold. Treatment for inguinal hernia, hip fracture and hospital care of acute myocardial infarction, however, was found to be remarkably uniform.[6] Wide variation seems to exist except for treatments about which there has been clear and longstanding agreement.

No explanation could be found for the great difference of practice styles except disagreement of physicians' opinions, translated into habits of practice. That they varied among, more than within, hospital staffs has been thought to result from peer influence and group behavior.

Why is there not agreement when presumably all read the same literature? Wennberg[5] suggested in 1982 that the impetus to variation lay with the supplier of care rather than with its recipient, and that the cause was "professional uncertainty." Eddy[7] elaborated the role of uncertainty in 1983. He said that widely varied and strongly held opinions can be explained only by lack of available comparative information about probable outcomes.

There is little variation when outcomes are generally known. Uncertainty and variation of practice result from an ambiguous medical literature, and inability of readers to recognize its statistical weaknesses: uncontrolled variables, faulty determination of probability of error or confidence interval, and very often inadequate sample size.

There are now several seemingly competing doctrines of change: outcomes, guidelines, and continuous improvement. Each has its advocates, but some find them compatible and are recommending their combination. For us to use them all or choose among them, we need to understand them. They will be examined in turn.

CQI

Continuous quality improvement and its variants were borrowed from industry. CQI (also known as TQM) was elaborated by Deming[8] to improve processes of production and distribution of manufactured goods. It may improve processes and efficiency in health care as it has in industry, but will it assure effectiveness?

Said another way, we may find ourselves doing better what isn't worth doing at all. CQI cannot help with what to do, but only with how to do it. Reinertsen[9] has called CQI a rudder, which is useless without the compass of outcomes.

Outcomes

Outcomes research is invoked often as an instrument of change, but usually with the glibness of the uninformed who know nothing of its limitations or its complexity. The concept came to public attention when C. Everett Koop was surgeon-general and promoted it as a guide to improvement.

Codman[10] proposed an "end result system" by which all patients would be followed until the results of their treatment was clearly apparent. He meant not only to compare methods of treatment, but also to score individual physicians and hospitals. What we now call profiling was odious in 1918 as it is today. As a result, Codman lost his membership in the local medical society and his chair of surgery at Massachusetts General Hospital.

Outcomes studies by their current connotative meaning address the patient's point of view. They test function in daily living, quality of life, and patients' satisfaction with result. They are not substitutes for randomized clinical trials, and must be no less rigorous than the best conventional research. Because they must follow patients to result of treatment, they will take longer than effect-specific or process research.

Even the lavishly funded, meticulously structured studies of the Patient Outcomes Research Teams of the Agency for Health care Policy and Research (AHCPR) will not resolve the simplest uncertainties in less than years and those more complex in less than a decade. Still, outcomes research is essential if ever we are to make sense of what we are doing. So what are we to do meantime?

Guidelines

Guidelines are anathema to many physicians who decry "cookbook medicine." Someone has said: "Everybody practices cookbook medicine. It's just that each has his or her own cookbook. We all have our favorite recipes."

Everybody is getting into the guideline business. The most expansive and expensive efforts have been those of AHCPR. They have cost between $350,000 and $800,000, and they have been the easy process types, such as perioperative pain management and decubitus ulcers. The tough ones will have to do with physician decision-making--what to do rather than how. The distinction is between process guidelines and cognitive guidelines.

Some terms that tend to be used interchangeably need to be defined and differentiated. Practice standards, sometimes called practice policies, are statements of what must be or is strongly recommended to be done. Practice parameters lay at the other end of the spectrum, describing the various methods that have been advocated and are considered to be acceptable--in effect, codifying and, by implication, justifying variation.

Between these extremes, practice guidelines (also called clinical care guidelines) are explicitly not mandates, but aids to making decisions. Properly made, they are based on structured review of what is known, and presented as a matrix, decision tree, or algorithm. Guidelines do not dictate or limit decisions, but provide best information from which to make them. The more than 1,500 entries in AMAs *Directory of Practice*

Parameters are a random collection of all of the above taken from all identifiable sources.

There are differing opinions about who should develop guidelines: agencies of government, agents of payers, national specialty organizations, or local physician groups. Those developed by AHCPR have been exhaustive but voluminous and better for study than daily use. Those guidelines or policies produced by specialty societies are most often written by panels of experts, the same ones who have written the inconclusive literature. Therefore, they tend to umbrella differing opinions, and have little effect on the variation they are supposed to correct.

There is advantage to development by the physicians who will use them. Creation of guidelines is excellent continuing education, and sense of ownership motivates their use. To avoid duplication of effort, there must be a means for sharing. Wennberg[11] advises: "The process of engaging in outcomes research and developing guidelines needs to be local, but the information base produced by that activity has to be shared across the country."

After being discussed and debated for several years to little effect, guidelines are now coming into use, but often at the behest of a purchasing group of financier of care. The form being taken is sometimes skewed to the purpose of cost containment and must be examined carefully to assure that quality is not sacrificed. Better yet, the initiative needs to be retaken by the health professions--by the users. The best guidelines will be our own. They should address high-frequency, high-cost conditions known to be treated variously. They must be concise enough for ready reference, yet comprehensive enough to cover the subject. They must be distributed widely, promoted by friendly persuasion, and put to use if they are to make a difference.

Those are the alternatives. How does one choose among them: continuous quality improvement, outcomes, or guidelines? In fact, they are not alternatives, but proper components of a continuum. Guidelines need to be developed by orderly process but taken as only present best guesses, subject to continuous review and revision. Outcomes assessment or measurements need to be standardized by consensus to provide comparable data for valid outcomes research by which to test

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practice guidelines and direct their revision. Only then does CQI finally have a rightful place. When we know what is best to do, "what works," these will describe the way to do it better.

Every guideline that is developed should have outcomes assessment method built into it. For many conditions the tools for outcomes measurement exist and are readily available. For others, they may also have to be created. The information gathering and evaluation, the structuring of processes for making decisions, and the tests of validity are continuing education at its very best. The work deserves to be rewarded, and to give continuing medical education credit would add incentive to participation.

No group of physicians will be able to address more than a few of the important uncertainties, and, therefore, sharing of information will be essential. Standardization of guidelines and valuative instruments will be necessary to avoid duplication of effort and to allow comparison of outcomes. That will require networking by agreement, coordination of effort and pooling of data, but for that a mechanism seldom exists. O'Connor[12] described a tri-state organization for outcomes research of cardiovascular disease as one of the study groups of the Maine Medical Assessment Foundation, but observed, "in most areas of the U.S., there is no existing infrastructure for such an endeavor." The problems have seemed to be getting started and getting organized.

At the 1993 SMS annual meeting, the House of Delegates approved the resolution: "that the State Medical Society of Wisconsin take aggressive leadership in the development, dissemination, and education regarding practice-based outcomes research to validate practice guidelines, by which to address practice variation and lead to appropriate change."

The Task Force on Quality Assessment and Implementation of Practice Parameters has been authorized to create a networking organization for collaboration of all of Wisconsin's stakeholders. There is a prototype in the Maine Medical Assessment Foundation[13] that has been the model for the regional professional foundations described by Wennberg and Keller,[14] and proposed in section 5008 of President Clinton's Health Security Act.

The purpose of the SMS task force is to develop an organizational structure by which the physicians of Wisconsin may exercise leadership in bringing about appropriate change, but in concert with all others having a valid interest. Professions are, by their nature, conservative and do not welcome change, but tend to react to change perforce. We now have a cause and an opportunity to lead. It gives one pause to note that Wennberg published his first provocative findings in *Science*,[5] the *Maine Medical Journal*,[15] and *Scientific American*,[16] and not in a mainline peer-reviewed medical journal. Our profession wasn't interested 20 years ago. Now one can scarcely find an issue of any major journal that doesn't carry some reference to these issues.

Relman[17] characterized the metamorphosis of medicine through the past half century as successive revolutions: first of expansion; second of payor revolt; and finally, now, the revolution of assessment and accountability. The physicians of Wisconsin need to be in the vanguard of this movement.

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The SMS-CESF Medical Outcomes Research Project

Jerry M. Ingalls, MD, Sally L. Wencel, JD, and Peter J. Alles, MPA, Madison

After reviewing the environment of cost, quality data collection and analysis, the State Medical Society of Wisconsin Task Force on Quality Assessment and Implementation of Practice Parameters concluded it is critical for the SMS to take a dynamic role in sponsoring the development and use of medical outcomes research. The initial emphasis will be on chronic diseases and health conditions representative of a large percentage of the Wisconsin patient population and involve physicians from diverse practice settings. The physicians of Wisconsin have a singular opportunity to seize the day by supporting and participating in a non-proprietary, regional study of patient medical outcomes. *Wis Med J.1994;93(8):433-437.*

THE SMS TASK FORCE on Quality Assessment and Implementation of Practice Parameters was appointed by the Board of Directors in September 1991 to ensure that Wisconsin physicians assume a knowledgeable role in the continuing discussion of quality medical care. The task force was also given the responsibility to develop a plan for the SMS in the assessment of quality and the implementation of practice parameters.

With this charge as its initial focus, the task force set forth with its own assessment of the state of the art of quality assessment activities. Among the presenters was a representative of what was then called InterStudy, a twin cities think tank founded by Paul Ellwood, MD. Although impressed with the strides made by InterStudy in pioneering this new approach to quality assessment called the Outcomes Measurement System, the task force concluded the time was not ripe for the SMS to endorse this quality assessment process. On July 18, 1992, the task force recommended to the Board that the SMS should be involved in the following activities:

- serve as a clearinghouse for the dissemination of information about practice parameters;
- assume a leadership role in educating physicians about quality improvement and review; and
- monitor the development of practice parameters, quality improvement and outcomes management.

The Board of Directors adopted the report and recommendations which served as the SMS plan for addressing medical quality assessment issues. Having accomplished its task, the task force was allowed to expire.

The 1993 SMS House of Delegates approved a resolution directing the SMS to "take aggressive leadership in the development, dissemination, and education regarding clinical outcomes research to validate practice guidelines by which to address practice variations and leading to appropriate change." This resolution gave a powerful direction to the SMS to take an active role in addressing the uncertainty surrounding whether practice parameters or guidelines and maintaining accountability to society for the development and implementation of quality assessment activities in the clinic. The task force was reconvened with this new direction in mind.

After reviewing the environment of cost, quality data collection and analysis, the task force concluded it is critical for the SMS to take a dynamic role in sponsoring the development and use of medical outcomes research. Specifically, the task force concluded the SMS should develop a medical outcomes research project to be implemented on a statewide basis.

There were several key reasons for this conclusion. First, the 1993 House of Delegates gave this edict. Second, there is an ever-growing interest expressed by both the public and private sector in practice guidelines and outcomes measures, although perhaps not with a thorough understanding of either concept and its proper application. As one example, the term "outcomes" is being frequently applied to data analysis using the gross parameters of mortality and morbidity.

Beginning in October 1993, HCFA redirected its contracting PROs to analyze physician practice patterns, benchmark facilities with good outcomes, and to develop practice guidelines, among other new quality improvement initiatives.[1,2] By defining the mean for the bell curve distribution of physician practice patterns, the assumption is that moving practices in one specific direction, ie, fewer radical prostatectomy procedures per 1,000 patients, will improve patient outcomes. Similarly, health insurers are applying critical pathways or practice guidelines to define cost-effective care. The task force expressed concern that data is not being collected from the clinicians and pa-

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tients to support the conclusion that good care results from the application of these "quality improvement programs."

Another concern outlined by the task force is the current lack of support for physicians engaged in provider contracting to demonstrate their good record with patient care. With the specter of being left out of major managed care provider networks for "quality reasons," physicians voiced the need for this sort of quality assessment tool to maintain their ability to practice medicine. Primary to this project (as described later) is the emphasis on providing aggregate data over patient populations and practice settings. As the science of outcomes research becomes more sophisticated, additional data features will be available to accurately risk adjust for comorbidities and other important distinctions in the patient outcomes data.

Finally, there is an important public policy objective served by medical outcomes research as its potential can be explored and expanded in the future. As medical outcomes research is fostered through this project, the profession may be moved toward the concept of a regional professional foundation[3] to develop lifetime learning, to ensure quality health care deliver, to foster collaboration between health plans and providers, to disseminate information about successful quality improvement programs, practice guidelines and research findings, among other quality of care promotion activities.

The task force made its recommendation to the SMS Board in February 1994 for the SMS to develop a medical quality research foundation, organized as a separate scientific foundation or folded into the existing Charitable, Educational and Scientific Foundation, and commence a medical outcomes research project. After accepting this report, the Board of Directors recommended this project for the 1994 House of Delegates' approval, which was given on April 15, 1994.

Medical outcomes research

It is important to point out what medical outcomes research is not: It is not based on information about the cost of care by extracting information from bills for health care. With ever-increasing frequency, the term "outcomes" is used by a variety of speakers with respect to data collection and analysis to determine whether "quality" health care services are being provided or purchased. Most often, the focus of data collection efforts have been on determining the "cost outcome" of health care rather than the patient's health outcome.

This emphasis is due to several factors. Perhaps the primary reason for this emphasis is that claims data has been the most traditionally available source of data. Starting with the Medicare program, claims data have been analyzed with the purpose of controlling program costs, including ferreting out provider and recipient fraud. The National Claims History System, a HCFA data reporting system that combines both Part A and Part B claims in a common file, has collected claims data for years and provides a wealth of both inpatient and outpatient payment information.

The other key reason for the emphasis on claims data for "outcomes" analysis is that medical care costs have been the major concern of those making the decision to collect data. In Wisconsin, the Office of Health Care Information has been collecting hospital discharge information since 1991, and began collecting ambulatory surgery data in 1993. The data analysis emphasis has been on mortality and morbidity comparisons, cost and length of stay measures per DRG (diagnostic related group). Although this Office of Commissioner of Insurance administered agency is attempting to glean other analysis from claims data, it is unable to do so because of the questionable integrity of this data.

Private carriers, managed care organizations and employer coalitions have also entered the data collection field and have also focused on claims data. The purpose of this data analysis is primarily to track health care program costs rather than quality data. The explanation has been that high cost care is often low quality care.

Within Wisconsin, there has been no statewide analysis of the effect of cost-based practice guidelines on patient care other than the information yielded from claims data. These quality measures are gross in nature--mortality, morbidity, and readmission--and tell little about the patient's status.

From the task force's perspective, "outcomes" data based on claims information is inadequate for quality improvement purposes. While the use of this data by managed care plans and insurers to monitor costs is certainly justified, data yielded by claims review does not tell physicians how to provide better care to patients. Also, there is an important use of this analysis to determine procedures or the treatment of certain health conditions in which there is wide variation. Mere variation, however, does not answer the question of what is the appropriate level of services. (See, Hoover N. *Wis Med J.1994;93(8):429-431.*) The focus is clearly on cost effective care and there is little scientific evidence offered to demonstrate that, for example, shortening hospital length of stay does not adversely affect the patient's health outcome. Claims data does not capture the full health care picture. Moreover, it has little credibility with practicing physicians and therefore is not effective in changing physician practices other than to comply with managed care guidelines.

Outcomes management system

As a result of the increased emphasis on claims data based "outcomes" information, the SMS task force reviewed the emerging science of medical outcomes research as originated by Paul Ellwood, MD, (described above) and now being promoted by the Health Outcomes Institute. This outcomes measurement system emphasizes the use of patient-reported information on health status and quality of life in conjunction with clinical and process measures reported by the patient's health care provider. The purpose of this study is to compare, account for, and manage the effects of ordinary medical care on patients' clinical status and quality of life.

Unlike claims data analysis, outcomes measurement and research provides one of the three critical features of a quality improvement program.[4] To put it another way, outcomes research establishes the effectiveness of medical care in the "real world" rather than determining the likelihood of effectiveness through the well-controlled conditions of clinical trials.[5]

As he described his patient-based clinical outcomes system,[6] Ellwood realized that health care costs were climbing, yet there was no way to accurately measure the real value of medical treatment. There was no proof that an extensive and costly medical treatment would result in better quality of life for that patient. He reasoned that costs would never be truly brought under control and quality would never truly be assessed until physicians can determine that x treatment will yield y outcomes at z cost. Only then can a rational, educated decision about treatment be reached. He challenged the medical community to participate in the development of his Outcomes Management System (OMS) and use its analysis to:

- follow the natural progression of health conditions;
- assess and choose the most appropriate therapies;
- establish standards for treatment of specific conditions;
- estimate resources to be used in treating conditions;
- predict the cost of care; and
- select the most efficient and effective providers of care.

This system, in other words, is a management tool--providing the information to feed back to physicians to improve the way in which they deliver health care to patients based on what is shown to work for patients.

The OMS is simple in design. It consists of simple questionnaires and data collection protocols to be used in collecting data in a common for-

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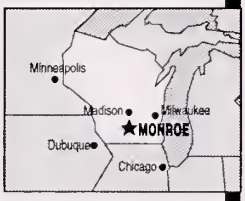

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- Send CV and Letters of Inquiry to:
  Physician Recruitment
  Park Nicollet Medical Center
  5000 West 39th Street
  Minneapolis, MN 55416
  or
- Fax 612/924-2819

Continued from preceding page
mat across patients, settings and conditions. The questionnaires consist of the health status questionnaire ("HSQ") that collects from patients self-reported quality of life, satisfaction, demographic, health behaviors and co-morbidity data. Through testing and retesting, a baseline for responses from healthy persons has been established against which the responses of patients with a medical condition is gauged. The closer the responses of the patient receiving treatment to the healthy baseline, the closer to "health" the patient appears to be.

The other information tool is the Technology of Patient Experience or "TyPE" form. This form is condition-specific and completed by patients and health care providers to collect demographic, comorbidity, and quality of life information as well as the clinical measures of a patient's condition and outcome. There are currently 16 TyPE forms available, including angina, asthma, cataracts, chronic obstructive pulmonary disease, chronic sinusitis, depression, diabetes, hip fracture, hip replacement, hypertension and lipid disorders, low back pain, osteoarthritis of the knee, prostatism, rheumatoid arthritis, stroke and substance use disorder (alcohol).

Data collected in a common format allows pooling of data and comparison of experience. An important feature of OMS is the emphasis given to patient-reported functional status and quality of life along with simple clinical and process measures. The volume and kinds of data required within the outcomes measurement system are kept small, making it more practical to collect these data as part of everyday practice. The outcomes measurement tools are placed in the public domain so as to minimize barriers to their use. Examples of current studies using the OMS include the American Group Practice Association in cooperation with over 50 member clinics, the Managed Health Care Association, HealthSpan, Inc., and the State of Oregon Medicaid Program.

At this writing, the task force is in the process of identifying health conditions to study to initiate the project. The initial emphasis will be on chronic diseases and health conditions representative of a large percentage of the Wisconsin patient population and involve physicians from diverse practice settings (ie, specialty clinics and multispecialty clinics, large and small medical offices). Also, the health conditions will be treated primarily on an outpatient basis, which would further distinguish this project from current data analysis projects with the traditional inpatient claims data approach. As interest and participation in this demonstration project grows, the task force will expand the research to include more health conditions.

Resources needed

The equipment and technology needed to implement an outcomes study in the clinic setting varies on practice size, patient population to be included and number of physicians participating. For a small patient study, paper forms may be collected and mailed or faxed to the SMS for data collection and analysis purposes. Larger medical groups may be currently collecting outcomes data and may submit data tapes or transmit the information via modem on a "real time" basis. As the project is implemented, the SMS will provide trainers and other technical support and assistance to project participants. Also, there is an expanding commercial interest in providing outcomes research technology and support and participants may elect to obtain both the technology and data analysis tools to perform the data collection and analysis on site. This internal data function may quickly enhance the clinic's quality improvement activities.

The process

Enrollment and record preparation. Each participating physician office or clinic ("participants") will select patients for enrollment in the study and establish files for information collected. These files can be made part of each patient's medical records, if desired. To ensure confidentiality and maintain a link between raw data and the patient medical records, physician offices will assign a code number to each patient enrolled. A brochure containing information on the project's purpose, intended uses of data, and methods for keeping individual responses confidential will be given to each patient at the time of enrollment.

In addition, a log will be maintained for patients choosing not to participate in the project. Knowledge of characteristics for non-participating patients may enable the project coordinators to determine if there is any systematic bias in enrollment. Patient comments on their reasons for not participating could also yield useful information with which to fine-tune project methodology. For example, if a significant number of patients refusing to participate indicate they are concerned about confidentiality, the project coordinators could use this information to consider adjustments to the informational brochure or other aspects of the research process.

Transmitting data. The demonstration project will be limited in scope and will make use of a general health status survey. Participants may choose to send survey data in several ways for the initial project. The forms can be mailed to the SMS as completed, or in batches. Alternatively, participants may choose to send surveys by fax, keeping the originals. Fax and scanning technology has improved markedly in recent years, reducing the incidence of errors related to transmission quality and making it possible to quickly screen forms for possible errors

during the scanning process.

As the outcomes research progresses beyond the demonstration project, physician offices and clinics choosing to participate may have to decide whether to purchase software and scanning equipment designed for outcomes research. Those choosing to do so will be able to enter their own data and send it to the SMSW by modem or on diskette.

The symposium

A specific project under way is to hold a Medical Outcomes Research Symposium Oct 14, 1994, in Lake Geneva at the Grand Geneva Resort and Spa. This symposium is designed to provide physician and health care industry leaders information about the SMS Medical Outcomes Research Project, to reach out to the health care delivery system about the project and to encourage participation of medical practices throughout the state. Category I CME credits are being applied for to award physicians who participate in this conference.

Conclusion

The physicians of Wisconsin have a singular opportunity to seize the day by supporting and participating in a non-proprietary, regional study of patient medical outcomes. The task force that recommended the SMS-CESF Medical Outcomes Research Project concluded that this system of data collection and analysis is the only viable means of performing quality assessment and is the critical but often missing link in a medical quality improvement program. While housed in the CES Foundation of the SMS, the project's emphasis is on cooperation between various organizations, health care delivery systems and local and national outcomes measurement projects. To learn more about the project, physicians and health care delivery leaders are encouraged to participate in the Medical Outcomes Research Symposium on Oct 14, 1994. For more information about the project or the symposium, please call the SMS: 800-362-9080 or, in the Madison area, 257-6781.

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Wisconsin physicians find free vaccines promote immunizations

FREE IMMUNIZATION programs increase the likelihood that a physician in private practice will offer immunizations to children, a recent study found. Lead author William J. Hueston, MD, of the Eau Claire Family Practice Residency Program, and colleagues conducted the study to examine state immunization distribution programs. The article appeared in the July issue of the *Archives of Family Medicine*.

The authors wrote: "Physicians who practiced in states that supplied childhood vaccines free of charge for use in Medicaid recipients were more likely to offer immunizations in their practices than were physicians in states that did not supply immunizations. This finding was constant in all three geographic areas." The survey sample included 287 practicing physicians in three states that participated in the Medicaid free vaccine program (Washington, South Dakota, and New Hampshire) and 266 physicians from three geographically matched states that did not participate (Oregon, North Dakota, and Delaware).❖

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New fraud and abuse safe harbors

Alyce C. Katayama, JD, Milwaukee

On Sept 21, 1993, the Office of Inspector General (OIG) of the US Department of Health and Human Services proposed to expand the list of safe harbors published in 1991. Like the 11 earlier safe harbors, the seven proposed safe harbors are designed to advise the health care industry which payment practices will not be subject to prosecution under the Medicare and Medicaid antikickback statute. The extremely broad statute prohibits offering anything of value in exchange for the referral of patients for services or goods which will be paid for by Medicare or Medicaid. The proposed regulations would create safe harbors for: rural area joint ventures, ambulatory surgical centers (ASC), group practices, practitioner recruitment, obstetrical liability insurance subsidies, specialty services referral agreements, and cooperative hospital service organizations (CHSO).

Rural joint ventures

For rural joint ventures, the proposed regulations would eliminate the two 60/40 rules contained in the small entity investment safe harbor. Those rules require that no more than 40% of the investment interests be held, and no more than 40% of the gross revenue be generated by, persons in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity.

In the place of the 60/40 rules, the proposed regulations would require the entity to make a bona fide offer of the investment interest to individuals or entities irrespective of whether they are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity. The OIG gives no indication of how many offers or what percentage of the offers must be made to persons not in a position to make or influence referrals.

In addition, to be safe harbored, the entity would have to derive at least 85% of its gross revenues in the previous fiscal year or 12 months from persons residing in a rural area. A rural area would be defined as a geographic area that is not a metropolitan area as defined by the Office of Management and Budget. In Wisconsin, West Bend, Stevens Point, and Watertown would be considered rural areas.

Ambulatory surgical centers

The OIG had spoken kindly of ASCs when the first set of safe harbors was published, so it was anticipated that the proposed regulations would create a safe harbor for payments to a free standing ASC. And they do.

This safe harbor would protect payments to ASC investors where all the investors are surgeons who are in a position to refer patients to the ASC and who in fact perform services in the ASC. OIG views the ASC as an extension of the investor surgeon's office practice.

Physician group practices

The OIG has decided to recognize the legitimacy of physician group practices. But there are some catches.

Specifically, The OIG proposes to protect payments to physicians who invest in a group practice of which they are active members. The terms of the investment interest could not be based on expected referrals, neither the entity nor another investor could lend or guarantee a loan used to obtain an investment interest, and the return on the investment would have to be directly attributable to the capital invested. The group practice seeking to enter this safe harbor must satisfy the statutory definition of a group practice. This definition was originally enacted as part of the "Stark I" and has been refined in the "Stark II" anti-self-referral provisions which were part of OBRA '93.

To satisfy this definition, the group practice must be legally organized in some fashion. Each physician member must provide substantially his or her full range of services through the joint use of shared office space, facilities, equipment, and personnel. Overhead expenses and income must be distributed on a predetermined basis. A group member cannot directly or indirectly receive compensation based on the volume or value of his or her referrals. A physician's orders for an item, service or consultation constitutes a "referral" for this purpose.

The OIG's use of this definition in a regulatory proposal represents a remarkable sleight-of-hand. Congress enacted this definition as one of the requirements to be met by a medical group seeking to qualify for an exception to the prohibition on physicians' referring to clinical laboratories, diagnostic imaging facilities, radiation therapy, physical therapy, and other specified businesses in which they own an interest. The OIG's use of that definition is another matter altogether--an attempt to generally regulate physicians' investment in their group practices, without any underlying statutory authority.

Equally disconcerting is the OIG's

Katayama is a partner in the law firm of Quarles & Brady. Reprint requests to: Alyce Katayama, Quarles & Brady, 411 E Wisconsin Ave, Milwaukee, WI 53202-4497. Copyright 1994 by the State Medical Society of Wisconsin.

comment about the group practice safe harbor in the preamble to the proposed regulations: "[W]e are soliciting information in [sic] the types of compensation arrangements that exist within group practices and the extent to which they create inappropriate incentives that distort the professional judgment of the members of the group." This is akin to having a government agency solicit comments on the sex lives of married couples to find out how they might be improved by regulation.

Practitioner recruitment

The proposed regulations would create a safe harbor for certain payments offered by rural hospitals and entities in efforts to recruit physicians and other practitioners to their staffs. This safe harbor would protect only recruitment activities directed at an established practitioner relocating to a new geographic area or a new practitioner following completion of an internship or residency program. No protection is offered for recruitment activities directed at established practitioners who are already working in the same geographic area.

For the recruitment activity to be protected:

- the arrangement would have to be in writing;
- for established practitioners, the physical location of the new primary place of practice would have to be at least 100 miles from the location of the former primary place of practice and at least 85% of the revenue from the new practice would have to be generated from new patients;
- the duration of the recruitment payments could generally not exceed 3 years;
- the agreement could not be conditioned upon the practitioner's referral of business to the entity;
- the practitioner would have to be free to establish staff privileges at or refer business to another entity, or both;
- the amount of the payment could not be based on the volume of business generated by the practitioner; and
- the practitioner would be required to treat Medicare and Medicaid patients. A rural area for this purpose is defined the same as in the rural joint venture safe harbor.

The proposed regulations would create a safe harbor to permit a hospital to pay malpractice insurance premiums for practitioners engaged in obstetrical practice, but only in primary care health professional shortage areas. To meet the proposed safe harbor:

- the agreement would have to be in writing;
- at least 85% of the practitioner's obstetrical patients treated under the malpractice coverage would be required to reside in the shortage area or be a part of a designated shortage area population;
- the practitioner could not be required to refer any level of patients to the hospital;
- the practitioner would have to be free to establish staff privileges at or refer patients to other hospitals;
- the amount of the subsidy could not vary based on referrals;
- the practitioner would have to be required to treat Medicaid patients seeking obstetrical care; and
- the payments would have to be for bona fide insurance policies. The proposed safe harbor would permit a hospital to limit the coverage of the malpractice insurance to services performed at that hospital.

Specialty services

The OIG has also proposed to provide safe harbors for arrangements under which a practitioner refers a patient to another individual or entity for specialty services and in return there is an agreement on the part of the party receiving the referral to refer that patient back at a certain time or under certain circumstances. Naturally, the proposed safe harbor would prohibit any payment between the parties for the referral. The only permissible exchange of value between the parties would be the "opportunity" to obtain payment from third-party payors or the patient for the professional services rendered. Payment between the parties would be permitted, however, where both parties belong to the same practice group in which revenues are shared among members of

Continued on next page

Participants needed for 1994 AIDS Walk Wisconsin

The 5th Annual AIDS Walk Wisconsin, scheduled for Sept 18, will raise funds for 20 AIDS service agencies throughout Wisconsin. The 10 K walk along Milwaukee's lakefront is the state's largest AIDS fund-raising event.

To register for the walk, send your name and address to AIDS Walk Wisconsin, PO Box 92487, Milwaukee, WI 53202-0487. The AIDS Walk office will immediately send you a sponsor form so you can start collecting pledges. Tax deductible contributions may also be sent to the above address. For information, call 1-800-348-WALK.❖

the group practice.

The OIG's decision to offer safe harbor protection to referral agreements is of little help to the health care industry. It is reminiscent of the OIG's 1991 safe harboring of physicians' ownership of the stock of publicly traded drug companies and other similar investment. On the bright side, by encouraging the "return" of the patient from the specialist to the primary care physician, the OIG is in sync with other federal policymakers.

CHSOs

Finally, the proposed regulations would create a safe harbor for most tax exempt CHSOs. This safe harbor would protect payments from a patron hospital to a CHSO to support the CHSO's operational costs and those payments from a CHSO to a patron-hospital that are required under IRS rules. Such payments have not generated much concern or scrutiny up to this point.

The safe harbor would require that the CHSO be wholly owned by its patron-hospitals. If a CHSO acts as a group purchasing organization or a patron-hospital obtains discounts as a result of the CHSO's activities, the proposed regulations would also require compliance with the already existing safe harbors for group purchasing organizations and discounts.

Comment

These new safe harbors are only in proposed form. Given that it took more than 2 years to get from proposed rules to final safe harbor published in 1991, some delays before these proposed safe harbors are finalized can be expected. Nonetheless, as a practical matter, the health care industry will currently rely on these proposed regulations as the primary guidance on the covered subjects until such time final regulations are promulgated.

Unfortunately, only a few of the proposed safe harbors offer guidance in the difficult areas of daily practice. It is important to remember that just because a payment practice does not fall within a safe harbor does not mean it is prohibited. Rather, it must be carefully analyzed to determine whether it falls within the reach of the fraud and abuse statute--a reach which the OIG's proposed grasp may well exceed.❖

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Public health

Arsenic in private drinking water wells in Outagamie and Winnebago counties, Wisconsin

Jay Goldring, PhD; Terry Haupert, BS; and Rick Stoll, BS, Madison and Green Bay

ARSENIC IS A NATURAL component of the Earth's crust and is found widely in the environment. When arsenic is mentioned, many people remember the play "Arsenic and Old Lace," in which three good-natured elderly sisters used arsenic to poison wealthy men. A vivid account of arsenic poisoning also occurs in Flaubert's *Madame Bovary* and Napoleon's death was said by some to have resulted from intentional arsenic poisoning. In modern times, arsenic is used in wood preservatives, some pesticides, and in the manufacture of glass and metal alloys for use in electronic components. Drugs containing arsenic are also used in the treatment of some tropical parasitic diseases.

Arsenic is found in soil and groundwater as arsenate (As+5) and arsenite (As+3). In biological systems, arsenate is reduced to arsenite, which is then converted to monomethyl arsenite (MMA) and dimethyl arsenite (DMA). In humans, ingested arsenic is distributed to all tissues and excreted as MMA or DMA in the urine within 1 to 3 days.[1] Ingested arsenic has also been found to concentrate in hair and nails.[2]

In both in vivo and in vitro experimental systems, inorganic arsenic has been found to inhibit a wide variety of enzymatic processes,[3] while the biological activity of organic arsenic species is highly variable. For example, most arsenic derivatives found in fish, such as arsenobetaine and arsenocholine, are thought to be essentially nontoxic[4] while arsenical pesticides and pharmaceuticals are used because of their toxicity.

The general population is estimated at approximately 46 µg of arsenic per day, mostly from food.[5] Foods with significant arsenic concentrations include seafood, especially shellfish, some meats and grains. Cigarette smokers inhale approximately 12 µg of inorganic arsenic per day. In 1978, the Environmental Protection Agency (EPA) banned the sale of arsenic-containing pesticides for home use. In a 1991 study, however, intentional or unintentional ingestion of these pesticides was responsible for a majority of arsenic poisonings seen in hospital emergency rooms.[6]

Arsenic in well water

Arsenic was first detected by the Wisconsin Department of Natural Resources (DNR) in well water in Winnebago County during a 1990 feasibility study for a proposed landfill site. Since that time, the DNR, the Wisconsin Division of Health, the Outagamie County Department of Human Services and the Winnebago County Public Health Nursing Service have collected data on arsenic concentrations in 1,943 wells in western Outagamie and Winnebago counties. Of those, 68 (3.5%) had arsenic concentrations exceeding the EPA drinking water standard of 50 µg/L and 622 (32%) exceeded 5 µg/L.

Individuals submitting water samples were also given health questionnaires administered by the Division of Health. The results of the health study will be published shortly.

The source of high arsenic concentrations in this area is believed to be the geologic contact between the St Peter sandstone and the overlying Platteville-Galena dolomite formation.[7] Core samples of sandstone and dolomite obtained from this

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Health effects of arsenic in drinking water.

Health effect	Water concentration (µg/L)	Reference
"Blackfoot Disease"*	170-800	9
Hyperkeratosis/nail ridging	1400-14000	9
Gastrointestinal irritation	>1400	16
Peripheral neuropathy	3000-1000	17

*Loss of circulation in hands and feet

contact contained up to 67 mg/kg arsenic. This contact exists in Wisconsin at varying depths in a line extending roughly from Marinette to Janesville.

Some groundwater taken from this formation in Outagamie and Winnebago counties has a unusually low pH, possibly promoting the leaching of arsenic.[7] Similar combinations of arsenic-containing geological formations and acidic groundwater leading to high well arsenic concentrations have been found in Oregon, Washington State, Argentina, Chile and Taiwan.

Based on these findings, the DNR has designated an "arsenic advisory area" (Figure). Press releases in 1992 and 1993 urged individuals living in this area to test their water for arsenic. Those with arsenic concentrations exceeding the EPA standard were given advice for correcting the problem. Preliminary investigations of areas with similar geology located immediately south and north of Winnebago and Outagamie counties have not yet identified similar arsenic concentrations, perhaps due to the lower corrosiveness of water in these areas.[8]

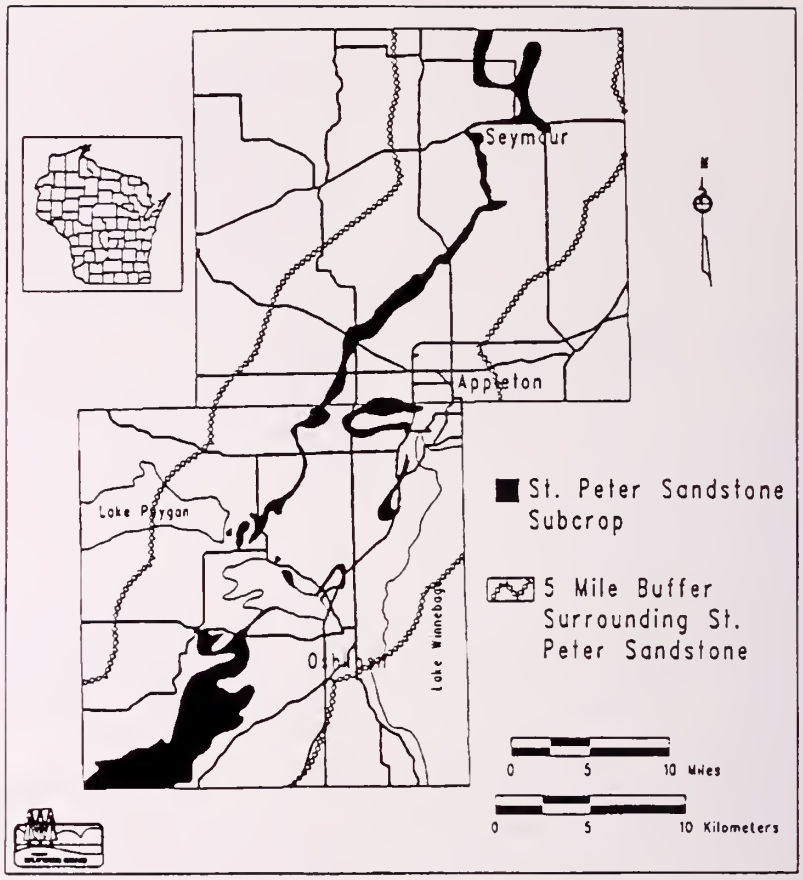

Fig.--Arsenic advisory area in Outagamie and Winnebago counties.

Health effects of arsenic

Due to the extensive publicity surrounding this issue, some Oshkosh and Appleton-area physicians have reported a number of patient inquiries regarding arsenic health effects and diagnosis of poisoning. Some patients have questioned whether current drinking water standards are adequately protective against these health effects.

Exposure to arsenic in drinking water at similar concentrations to those found in Wisconsin has been reported to cause a number of health effects (Table). In addition, a number of studies conducted in Taiwan and other foreign countries indicate that consumption of arsenic-contaminated water can lead to an excess risk of basal and squamous cell carcinomas of the skin and possibly lung, liver and bladder cancer.[9] These studies are ecologic in design and have not been confirmed in the United States.

Although arsenic has not been shown to induce cancer in any experimental animals studied, the epidemiologic evidence has led the International Agency for Research on Cancer to conclude that there is "sufficient evidence that inorganic arsenic compounds are skin and lung carcinogens in humans."[10] The mechanism of carcinogenesis is thought to involve inhibition of DNA repair enzymes and subsequent decreased repair rates of ultraviolet light-induced DNA damage in the skin.[3]

The current EPA arsenic standard is based upon the estimate that humans consume approximately 900 µg of arsenic per day and that arsenic from drinking water should comprise no more than 10% of total ingested arsenic.[11] In a recent article, however, Smith et al[12] review both drinking water and occupational arsenic exposure studies and conclude that lifetime consumption of water contaminated with arsenic at the current EPA standard would be associated with an excess risk of skin, liver, lung, and bladder cancer as high as 1 in 100. In addition, calculations for the current EPA standard did not take into account the differing toxicological properties of inorganic and organic arsenic. As a result, EPA is under court order to issue a proposed new rule by September 1994 and a final rule by September 1996.

These relatively high calculated cancer risks could lead EPA to revise the arsenic standard to the practical detection limit, as low as 5 µg/L. Adoption of this standard, how-

ever, could cost more than $6 billion to US water utilities, who would have to install treatment to comply. In Wisconsin, 5% of public water systems would be required to install such treatment, costing an estimated $30 million.[13]

Advice for concerned patients

Area physicians have reported two commonly asked questions from concerned individuals:

- How can I be tested to see if the arsenic in my water has affected my health? and
- How can I obtain a safe water supply?

All non-cancer arsenic-related health effects are thought to disappear once the exposure ceases.[14] Therefore, long-term chronic health effects are unlikely. For individuals concerned about cancer risk, adequate sun protection is advised regardless of whether arsenic exposure has been significant.

Urinary arsenic testing is not useful if the exposure ceased more than 2 days prior to the test. Hair arsenic concentrations, however, can provide a useful indicator of arsenic exposure within the past 6 to 12 months (providing that the hair has not been cut since that time). Results of hair tests should be used with caution, however, because they may reflect exogenously deposited, as well as systemically absorbed, arsenic.[15] Arsenic hair tests are available from the Wisconsin State Laboratory of Hygiene; for instructions, call Jay Goldring at the Wisconsin Division of Health, (608) 266-7480.

Those wishing to lower the arsenic concentration in their wells can install either a treatment device or construct a new well. State approved reverse osmosis units costing $500 to $1,000 are commercially available to lower arsenic concentrations to below the drinking water standard. The DNR has specific guidelines for constructing new wells. For information on both of these options, contact Rick Stoll at the DNR, (414) 492-5896.

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Physician satisfaction with the development of HMOs in Dane County: 1983-1993

William E. Scheckler, MD; Rockwell Schulz, PhD; and Paul Moberg, PhD, Madison

In September 1993, the 1,196 active physicians in Dane County were surveyed to learn their satisfaction with the development of HMOs and comparisons to similar satisfaction surveys in 1986 and 1983. Among the 675 usable responses, 65% reported that they were satisfied or very satisfied with their current work, which is about the same as the 1986 survey when 68% reported that they were satisfied. Other findings suggest support for HMO development in Dane County. Moreover, 66% reported support for the basic principles of the Clinton health system reform plan announced in September 1993. *Wis Med J.1994;93(8):444-446.*

HEALTH SYSTEM REFORM legislation is occupying considerable attention in the current session of Congress. Most of the plans being discussed envision some array of managed care systems as integral mechanisms to provide quality health care at an affordable cost. No consensus has yet emerged since President Clinton articulated his six key points for health system reform to a joint session of Congress on Sept 23, 1993.

We have been studying the satisfaction of the practicing physicians in Dane County, Wisconsin, with health maintenance organization (HMO) development since 1983. Results of our surveys in 1983 and 1986 have previously been published.[1,2,3]

The day after the Clinton presentation to Congress, we surveyed all of the physicians in Dane County again to assess their satisfaction with their practices and with different types of managed care. We believe that the results of the current survey, compared to our previous survey, can help inform Wisconsin physicians about the state's experience with managed care and its implications for the current state and national discussions of health system reform. Therefore, we are presenting this report as the preliminary analysis of our 10-year study.

Dr Scheckler is with the University of Wisconsin-Madison Medical School, Department of Family Medicine. Dr Schulz is with the UW Department of Preventive Medicine. And Dr Moberg is with the UW Center for Health Policy and Program Evaluation. Reprint requests to: William E. Scheckler, MD, University of Wisconsin School of Medicine, Dept of Family Practice, 777 Mills St, Madison, WI 53715-1896. Copyright 1994 by the State Medical Society of Wisconsin.

Methods

The four community hospitals in Dane County, (the University of Wisconsin Hospital, Meriter Hospital, St Marys Hospital Medical Center, and Stoughton Hospital) provided alphabetized rosters of their active medical staffs by specialty in the summer of 1993. Duplications in the lists from the hospitals were eliminated. The Middleton Veterans Administration Hospital and resident physicians were not included.

Each active staff physician was assigned an identifying code for confidentiality. The codes were used to identify responders so they were not sent repeat questionnaires. One primary and three follow-up mailings were sent. There was a final telephone contact of non-respondents requesting return of the survey.

The survey included the same questions and scales present in the 1983 and 1986 surveys. It was four pages long and had 18 separate questions.

Responses were entered into an SPSS/PCT computer data base by staff from the University of Wisconsin Center for Health Policy and Program Evaluation. The initial analysis is from the frequency counts of all responders to the 1993 survey questions.

Results

Responses were returned from 736 of the 1,196 active staff physicians surveyed in 1993, for a 62% response rate. Sixty-one responses were not useable because respondents were not in active practice, not in the state or the responses were incomplete. Comparable response rates were 58% of 842 physicians surveyed in 1983 and 65% of the 850 physicians surveyed in 1986.

In 1986, 14% of the respondents were women. In 1993, 18% were women. Table I compares the 1986 and 1993 respondent group by specialty, age, year in which they started practice in Dane County, and percent involved in HMO practice.

Physicians as a group continue to be very involved in HMO patient care. In 1986, half of the respondents indicated their practice had 25% or less HMO patients. In 1993, only one quarter of respondents reported that 25% or less of their patients were from HMOs and about one third said 50% or more of their patients were from HMOs. This change reflects a substantial growth in HMOs from 1986 to 1993.

Physicians continue to be supportive of HMO development and believe that HMO care is cost effective. In 1993, 65% of respondents were "very supportive" (19%) or "supportive" (46%) of Dane County HMO development. An Additional 24% were "neutral." Only 11% were "opposed" and only 2% "very opposed" to HMO development.

This high level of support has continued since 1986. Of the 1993 respondents, 11% indicated their support for HMO development had decreased since 1986, and 27% indicated their support had actually increased in the 7 years. Half of the respondents (50%) believed that HMO care provides more cost effective medical care than standard fee-for-service care, and 12% believe HMOs are less cost effective. This information is summarized in Table 2.

Several questions were asked about satisfaction with various aspects of the physician's practice and the degree of autonomy associated with that practice. Respondents were asked to compare and contrast their answers for three categories of patient: HMO, fee-for-service, and Medicare.

In general, physicians were most satisfied with their ability to manage the health of fee-for-service patients, with only 1% to 3% being dissatisfied or very dissatisfied with the various options.

They were also satisfied or very satisfied with the various options for their fee-for-service patients. When asked to rate the "amount of income you receive" from each category of patient, 1% of respondents were dissatisfied or very dissatisfied with income from their fee-for-service patients, 10% with their HMO patients and 36% with their Medicare patients. Respondents were very satisfied in all three patient groups with the amount of time they have to spend with each patient, their relationships with patients, the kinds of patients and clinical problems seen, and the potential for improving the health of patients. More than twice as many respondents were dissatisfied or very dissatisfied with the amount of paperwork that Medicare patients require compared to HMO or fee-for-service patients.

The respondents were asked: "All in all, how satisfied are you with your current work situation?" Among 1993 respondents, 65% were satisfied or very satisfied compared with 68% in the 1986 survey. The level of dissatisfaction was quite low with 2% indicating they were dissatisfied and 1% very dissatisfied. This was unchanged from 1986.

The first question in the survey asked: "Based on what you know about the proposed Clinton health care reform plan, do you strongly support, support, oppose or strongly oppose it." Of the 652 physicians who responded to this question, 7% indicated strong support, 59% indicated support, 23% indicated opposition, 10% indicated strong opposition, and 1% were neutral. It should be noted that the survey was largely conducted before the specific details of the Clinton and most other health plans were known.

Discussion

Dane County physicians have now had more than 10 years of experience with HMOs as a form of managed medical care.

Prior to the change, in 1983, a survey of those physicians showed substantial concern for the consequences of HMO development. They expressed concern about both practice satisfaction and practice autonomy. Our earlier papers[2,3] demonstrated that the same physicians responding to a survey in 1983 on their anticipated satisfaction with HMOs that were forthcoming, and in 1986 after experiencing HMO practice, expressed much more satisfaction with HMOs in their practices than they had predicted.

HMOs have continued to grow in Dane County and in Wisconsin since 1986. Two of the community hospitals and the major group practices and HMOs from those two hospitals have undergone mergers. The two hospitals are now one, as are the two HMOs associated with those hospitals. The staff model HMOs in the community and at the University Academic Medical Center now

Table 1.--Dane County physician survey respondent characteristics.

Characteristics	1986 Respondents (n=545)	1993 Respondents (n=675)
Primary care specialties*	28%	30%
Hospital-based specialties**	14%	16%
Referral-based specialties+	58%	54%
46 years old or younger	57%	61%
Began Dane County practice in 1984 or later	6%	36%
Participate in at least one HMO	94%	93%

* Self-identified in family practice, general internal medicine, general pediatrics, or primary care OB/GYN
** pathology, radiology, anesthesia and emergency room physicians
\+ All surgical fields, psychiatry, medical and Pediatric subspecialties and all other physicians

have a major cooperative agreement. The other community hospital and the HMO associated with its major medical group have also continued to grow.

The five HMOs headquartered in Dane County accounted for 28% of the HMO enrollment of 1.1 million Wisconsin residents in 1993 and 28% of the $1.6 billion in revenue of the total 22 HMOs in Wisconsin in 1993.[4]

Except for the co-operatively owned staff model HMO, the leadership and control of the other HMOs are the responsibility of the physicians in the various medical groups. This sense of local control may be a major factor in the satisfaction voiced by Dane County physicians.

Our previous studies also showed substantial patient satisfaction with the growth of HMOs.[1] The continued increase of patients in HMOs in Dane County, now estimated at more than 50% coverage of the non-Medicare population, speaks to that satisfaction. More than 95% of Dane County state and university employees and staff now have HMO coverage as compared to 85% in 1984. In Wisconsin as a whole, 23% of the citizens are in HMOs, which ranks Wisconsin 10th among the 50 states in HMO participation.[4]

Also worthy of comment is the substantial 66% physician support for the basic six principles of the Clinton health system reform plan. The survey was initially sent out the day after the September address by the president to a joint session of Congress. One might assume that a physician community with substantial experience within a managed care system was not put off by the incorporation of managed care into health care reform.

Table 2.--Dane County physician responses to HMO development.

Category	1993 Response
Regarding HMO development in Dane County	
Very supportive	19%
Supportive	46%
Neutral	24%
Opposed	11%
Level of support for HMO development since 1986	
Increased	27%
Decreased	11%
Cost-effectiveness of HMO care v fee-for-service care	
More cost-effective	50%
Less cost-effective	12%
Overall level of satisfaction with current practice	
Satisfied or very satisfied	65%
Dissatisfied or very dissatisfied	3%

But we also need to note that the greatest level of concern expressed by the responding physicians in 1993 was over autonomy and satisfaction issues with Medicare. Almost half of the physicians were unhappy with Medicare reimbursement levels and Medicare paperwork. It would seem that a simple expansion of Medicare would not meet with physician favor. In general physicians continue to be most satisfied with their fee-for-service practice.

This paper is a preliminary review of the answers by 675 Dane County physicians to a complex survey. Additional analysis by specialty, practice group and other variables are under way. We present our preliminary information above to the readers of the *Wisconsin Medical Journal* and our colleagues because we think this information would be very useful to policy makers and our representative now. Based on our previous work, we believe the respondents are likely to be representative of their colleagues in the community. Stay tuned.

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3. Schulz R, Girard C, Scheckler W. Physician Satisfaction in a Managed Care Environment. *Journal of Family Practice*.1992;34:3:298-304.
4. Lautenschlager S. HMO Participation is Rising. *Wisconsin State Journal*.May 22,1994:1-2(E). ❖

SMS issues call to action on health system reform

In the Aug 1 edition of *Medigram*, the SMS issued a call for a concerted grassroots effort on health system reform. All SMS members were strongly urged to contact their elected representatives in Washington, DC, and express support for comprehensive health system reform, particularly emphasizing the need for guaranteed health insurance. The SMS has identified eight essential elements to meaningful reform:

Guaranteed health insurance
All Americans must have insurance that provides access to high quality, affordable health care if reform is to be achieved.

Tort reform
Capping non-economic damages in medical professional liability cases is a fair way to help control costs and still make sure an injured patient is compensated. A cap of $250,000 is included in the Senate Finance Committee's reform bill, and it warrants our support.

Right to select one's own physician
Unless the patient is comfortable with the physician, health care will suffer. The freedom to choose is essential.

Standard benefits package
A standard benefits plan is essential because it will help ensure equity of health care coverage and access, regardless of employment or income.

Community rating
Insurers must eliminate the problems some employers and individuals have in securing coverage due to pre-existing health conditions.

Insurance industry reforms
Insurers must provide coverage without regard to waiting periods and pre-existing conditions. Insurers must renew all policies and provide for converting employees to individual or family based coverage on termination of employment.

Portability
Americans must not be forced to stay in a particular job for fear of losing health care coverage.

Real negotiation on fees
True negotiating between providers and purchasers must occur and cost shifting must be eliminated by government agencies adequately funding their share of health care costs.

The SMS is also supporting essential anti-trust reforms that will allow physicians to compete fairly with insurance companies and hospitals. Senate Bill 1658 contains these reforms, and the SMS is urging Wisconsin's senators to include them in health system reform legislation.❖

Deadline for WMJ special issue approaches

The *Wisconsin Medical Journal* seeks articles from Wisconsin physicians on the subject of gun violence, exploring its nature, causes, costs, effects and possible solutions, and the deadline for submitting papers is quickly approaching. This special issue, originally scheduled for September, has been changed to October to coincide with "Child Health Month." Papers must be submitted by Sept 1 to receive consideration by the Editorial Board.❖

Dr Roberts carries SMS message to Washington

After a July trip to Washington, DC, in which he met with White House staff to reiterate the SMS positions on health system reform, SMS President Richard G. Roberts, MD, JD, has written to Sen Herbert Kohl and Sen Russell Feingold exhorting both to support guaranteed health insurance in health system reform. As of this writing, Feingold has expressed support for guaranteed health insurance; Kohl has remained undecided. The letter to Kohl also requested a meeting with Roberts, SMS staff and other community leaders to discuss health system reform issues in greater depth.

"Wisconsin has much to offer the nation in terms of successful health system reforms. We must make ourselves heard in Washington," Roberts said. "History must not record that we were silent while Congress made arrangements for our patients' care." Wisconsin AMA Delegate Cyril M. "Kim" Hetsko, MD, also participated in the special Washington session.❖

Reach the SMS toll-free 1-800-362-9080

Wisconsin Congressional Delegation

Russell Feingold: Senator - Democrat
Room 502, Hart Senate Office Building, Washington, DC 20510-4904; (202) 224-5323. Madison area office: 8383 Greenway Blvd, Middleton, WI 53562; (608) 828-1200.

Herbert Kohl: Senator - Democrat
Suite 330, Hart Senate Office Building, Washington, DC 20510; (202) 224-5653. Madison office: 14 W Mifflin St, Suite 312, Madison, WI 53703; (608) 264-5338.

Peter Barca: 1st District - Democrat
Suite 1719, Longworth House Office Building, Washington, DC 20515; (202) 225-3031. District offices: 20 S Main St, Janesville, WI 53545; (608) 752-9074 or 411 6th St., Racine, WI 53403; (414) 632-4446.

Scott Klug: 2nd District - Republican
Suite 1224, Longworth House Office Building, Washington, DC 20515; (202) 225-2906. District office: 16 N Carroll St, Madison, WI 53703; (608) 257-9200.

Steve Gunderson: 3rd District - Republican
Suite 2235, Rayburn House Office Building, Washington, DC 20515; (202) 225-5506. District office: 622 E Highway 54, PO Box 247, Black River Falls, WI 54615; (715) 284-7431.

Gerald Kleczka: 4th District - Democrat
Suite 2301, Rayburn House Office Building, Washington, DC 20515; (202) 225-4572. District office: 5032 W Forest Home Ave, Milwaukee, WI 53219; (414) 297-1140.

Thomas Barrett: 5th District - Democrat
Suite 313, Cannon House Office Building, Washington, DC 20515; (202) 225-3571. District office: 135 W Wells St, Suite 618, Milwaukee, WI 53203; (414) 297-1331.

Thomas Petri: 6th District - Republican
Suite 2262, Rayburn House Office Building, Washington, DC 20515; (202) 225-2476. District office: 845 S Main St, Suite 160, Fond du Lac, WI 54935; (414) 922-1180. Toll-free: (800) 242-4883.

David Obey: 7th District - Democrat
Suite 2462 Rayburn House Office Building, Washington, DC 20515; (202) 225-3365. District office: 317 First St, Wausau, WI 54401; (715) 842-5606.

Toby Roth: 8th District - Republican
Suite 2234, Rayburn House Office Building, Washington, DC 20515; (202) 225-5665. District office: 126 N Oneida St, Appleton, WI 54911; (414) 739-4167.

James Sensenbrenner: 9th District - Republican
Suite 2332, Rayburn House Office Building, Washington, DC 20515; (202) 225-5101. District office: 120 Bishop's Way, Brookfield, WI 53005; (414) 784-1111.❖

SMS board approves plan for joint conference on gun violence

THE SMS WILL co-sponsor a regional conference on firearms violence in January 1995 due to action taken at the July 16 SMS Board meeting. Joining forces with the Medical College of Wisconsin departments of emergency medicine and continuing education and research and the Marquette University Office of Urban Affairs, the SMS will provide a forum for physicians, social scientists, law enforcement specialists and others interested in public health issues to discuss the health implications of firearms, including the incidence and severity of firearm injuries and fatalities. The primary goals for the 2-day program, set for Jan 12-13, are to increase participants knowledge and understanding of firearms, firearm injuries and firearms as a public health problem; and to identify options for public health policy on firearms. Attorney General James Doyle is expected to deliver the keynote address. Stephen Hargarten, MD, MPH, and Timothy Van Susteren, PhD, both of MCW, are heading up the program planning committee.

In other business July 16, the SMS board:

- voted to join the Wisconsin chapters of the American Heart Association, the American Lung Association and the American Cancer Society in a friend-of-the-court brief supporting a Fond du Lac ordinance requiring retailers to keep single cigarette packs behind the counter as a means of restricting youth access to tobacco;
- approved the following appointments: Michael P. Cinquegrani, MD, of Milwaukee, to the Governmental Affairs Commission as the cardiology section representative; James A. Avery, MD, of Fond du Lac, to the Governmental Affairs Commission as the surgery section representative; Gregory A. Shove, MD, of Racine, to the Commission on Health Care Financing and Delivery; Judith D. Pruski, MD, of Fond du Lac, to the Commission on Injury Prevention and Control; and Scott S. Erickson, MD, of Marshfield, to the Commission on Geriatric Health;
- approved the bylaws for the SMS Section on Group Practice; and
- approved funding for a medical outcomes research symposium.❖

Wisconsin delegation carries resolutions to AMA

MEMBERS OF THE SMS delegation to the AMA carried four resolutions to the AMA annual meeting in Chicago, held June 12-16. The resolutions included:

- Resolution 127 opposed the creation of a national health board that does not include a physician. *Action:* the AMA House of Delegates adopted a substitute resolution reaffirming existing AMA policy opposing the concept of a central board to govern private sector health care coverage.
- Resolution 215 addressed concerns relating to the all-payor health care fraud and abuse enforcement program as described in the Clinton Health Security Act of 1993. *Action:* adopted.
- Resolution 312 objected to implementation of federal quotas for medical education and specialty residency limits. *Action:* the AMA adopted reports of the Council on Medical Education and the Council on Long Range Planning, which contained the basic principles of this resolution.
- Resolution 326 recommended that the AMA develop guidelines on scope of practice for nurse practitioners and physician assistants. *Action:* the AMA approved a study from which a report is due at the 1995 annual meeting.❖

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Court reinstates MinnesotaCare challenge

THE MINNESOTA Supreme Court unanimously reinstated June 30 the physician challenge to the MinnesotaCare tax on health care providers who live and practice outside of Minnesota, but treat Minnesota patients. Effective for services performed as of Jan 1, 1994, the tax stands to have an impact on the practice of numerous Wisconsin physicians.

The MinnesotaCare Act imposes several new taxes to finance health reform in that state and to benefit uninsured Minnesotans, including a tax on the gross revenues received by physicians and hospitals for services provided to Minnesota patients. For physicians who live and practice outside Minnesota, the tax is two percent of the money they receive for treating Minnesota patients. Medicare and medical assistance payments are exempt from the tax. Physicians are allowed to raise fees to cover the tax.

The SMS has financially supported several physicians, including three from Wisconsin, who have filed a lawsuit challenging the constitutionality of the MinnesotaCare tax as applied to out-of-state providers. The Minnesota trial court dismissed the suit on the basis of a statute which Minnesota enacted after the litigation was brought. The court interpreted the statute to prevent physicians from suing until the state assesses or attempts to collect the tax. That decision was appealed.

The Supreme Court of Minnesota reversed that decision June 30, stating that where there is a clear challenge to the constitutionality of a state statute, the matter must be resolved as promptly as possible to "prevent placing an unconstitutional burden on the taxpayer." The case now returns to trial court for a ruling on the merits of the constitutional claims. ❖

Physician briefs

The * indicates a member of the SMS.

Samuel Abbate, MD,* an endocrinologist at Marshfield Clinic, was recently named the 1994-95 president of the American Diabetes Association, Wisconsin affiliate. Dr Abbate joined Marshfield Clinic in September 1991 after competing an internal medicine residency in Ohio. He is an alumnus of the University of Illinois College of Medicine.

Masood Akhtar, MD, of Elm Grove, was recently named president elect of the American Heart Association. Dr Akhtar is a professor of medicine at the University of Wisconsin Medical School-Milwaukee clinical campus; director of arrhythmia service and clinical electrophysiology at Milwaukee Heart Institute, Sinai Samaritan Medical Center; and staff electrophysiologist at St Luke's Medical Center. He also practices at Bellin Memorial Hospital in Green Bay, St Elizabeth Hospital in Appleton, Theda Clark Regional Medical Center in Neenah and Lutheran Hospital in La Crosse.

Catherine Best, MD,* will provide care at the newly opened Sheboygan Clinic in Howards Grove. Dr Best received her medical degree at the University of Wisconsin, then completed a family practice residency at St Joseph's Hospital Center in Syracuse, NY. She is board certified.

Laura V. Calderwood, MD,* has joined the medical staff of the new Mercy Walworth Medical Center. Dr Walworth comes to Wisconsin from Spokane where she was on the medical staff of Sacred Heart Hospital since 1986. She earned her medical degree from the University of Iowa and completed a psychiatric residency at University of Iowa Hospitals and Clinics.

Hulon Crayton, MD,* a rheumatologist at Kurten Medical Group in Racine, has been appointed for a 3-year term on the board of directors for the Wisconsin Chapter of the Arthritis Foundation. He is a graduate of the University of Wisconsin. He completed a residency in internal medicine and a fellowship in rheumatology with UW Hospital and Clinics. He is board certified.

William T. Franks, MD,* has joined the Montello Family Practice Center. Board certified in family medicine, Dr Franks graduated from the University of Indiana School of Medicine. He completed a family practice residency at Ball Memorial Hospital in Muncie. He comes to Wisconsin from Kamiah, Idaho.

Kristie L. Gast, MD, is a new

member of the Marshfield Clinic staff. Dr Gast served her residency in radiation oncology and earned her medical degree at the University of Kansas Medical Center in Kansas City.

Walter J. Hogan, MD, of Elm Grove, has been named alumnus of the year by the Medical College of Wisconsin/Marquette Medical Alumni Association. Dr Hogan, an internally recognized gastroenterologist who is professor of medicine and chief of the division of gastroenterology at the Medical College of Wisconsin, practices at Froedtert Memorial Lutheran Hospital and the Veterans Affairs Medical Center in Milwaukee.

Jeffrey D. Hosenpud, MD, of Milwaukee, has been appointed professor of medicine and chief of cardiology and hypertension at the Medical College of Wisconsin. Dr Hosenpud is a councilor of the International Society for Heart and Lung Transportation, chair of the scientific committee of the United Network for Organ Sharing (UNOS) and medical director of the Registry of the International Society for Heart and Lung Transplantation. Dr Hosenpud is based at Doyne Hospital.

David Israelstam, MD, of Madison, is one of three Wisconsin recipients of the 1994 National Alliance for the Mentally Ill (NAMI) Exemplary Psychiatrist Award. Dr Israelstam practices child, adolescent and adult psychiatry with Grand Teton Mental health Consultants in Madison.

James Jefferson, MD,* of Madison, is one of three Wisconsin physicians honored with the 1994 National Alliance for the Mentally Ill (NAMI) Exemplary Psychiatrist Award. Dr Jefferson is a senior scientist with the Dean Foundation for Health, Research and Education.

Thomas Kowalski, MD,* has been appointed health commissioner of the Greendale Health Department. Dr Kowalski is a faculty member for the Medical College of Wisconsin and is board-certified in pediatric and neo-natal medicine. In addition, Dr Kowalski serves as medical advisor for the Cudahy Health Department.

Dennis Maki, MD, a University of Wisconsin Medical School faculty member, is the recipient of the 1994 International Congress on the Prevention of Infection Award. The CIPI award was recently presented at a conference in France. Dr Maki has played a leading role in researching and developing techniques to diagnose, trace and prevent hospital-acquired infections. A graduate of UW Medical School, Dr Maki has won six teaching awarded and authored more than 200 research papers. He is section head of infectious disease at UW Hospital and Clinics.

Shaun J. Melarvie, MD, a general surgeon, is a new member of the medical staff of Bay Lake Outpatient Surgery Center. He earned his medical degree from the University of North Dakota School of Medicine in 1989 and recently completed a five-year residency in general surgery at the University of Nebraska in Omaha.

Continued on page 453

Environmental health commission selects study topics

The SMS Commission on Environmental and Occupational Health completed its 1994 summer planning session July 22, identifying a wide range of topics for future study and possible action. The commission, chaired by Mark A. Roberts, MD, of Milwaukee, will meet four times during the next year (Oct 19, Nov 30, March 1, and May 17).

EOH commission members will consider the following issues, including:

- tobacco use, its health care implications, and how the commission can more directly affect the problem;
- upcoming changes to OSHA standards and requirements specifically for blood-borne pathogens and tuberculosis;
- drinking water quality issues and implications in light of the cryptosporidium outbreak in Milwaukee;
- treatment for elevated lead levels, particularly for adults; and
- changes being made on the state's Worker's Compensation UCR database system.

The SMS commission will also follow the potential mining at the Crandon-Mole Lake site and its health care implications, and the numerous revisions to the state's administrative rules on public health.

At the Oct 19 meeting, Greg Krohm, administrator of the state's Worker's Compensation Division, will speak to the group about improvements in the database system. For more information, contact Lynn Sherman at 1-800-362-9080 or, in the Madison area, (608) 257-6781.❖

CHARITY GOLF CLASSIC SPONSORS

The Charitable, Educational and Scientific Foundation would like to acknowledge the following companies and individuals who contributed to the fifth annual Charity Golf Classic. The success of the event can be attributed to the dedication, energy, and financial commitment of these sponsor participants:

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Wisconsin Physicians Service

Golfers enjoy the day at the Tuckaway Country Club on behalf of the CESF Charity Golf Classic.

Continued from page 451

Thomas Midthun, MD,* of Baraboo, has earned a master's degree in public health from the Medical College of Wisconsin. Dr Midthun is the medical director of St Clare Occupational Health Services at St Clare Hospital and Health Services in Baraboo. He is a 1975 graduate of the University of Wisconsin Medical School. He completed a residency in family practice at the University of Iowa and is board certified in family and geriatric medicine.

Richard A Moran, DO,* has joined Pewaukee Medical Clinic. Dr Moran graduated from the Chicago College of Osteopathic Medicine and completed his residency in family practice at Lakeview Hospital in Milwaukee.

Pablo Pedraza, MD,* of Milwaukee, has been appointed to the Wisconsin Medical Examining Board by Gov Tommy Thompson. Dr Pedraza is a cardiovascular surgeon who joined St Mary's Cardiac Care Center in 1977.

Ken Robbins, MD,* of Madison, is one of three Wisconsin physicians recognized for earning the 1994 National Alliance for the Mentally Ill (NAMI) Exemplary Psychiatrist Award. Dr Robbins is medical director of Mendota Mental Health Institute.

Jerry R. Salan, MD,* has been named Wisconsin Family Physician of the Year by the Wisconsin Academy of Family Physicians. Dr Salan is the founder of Waupaca Family Medicine Association, which has eight family practice physicians and a general surgeon on its staff. Dr Salan has been providing primary care to Waupaca-area families since 1963.

Walter Schwartz, MD,* has received the outstanding district service award from the American College of Obstetricians and Gynecologists. Dr Schwartz has practiced with OB-GYN Associates of Wauwatosa, since 1961 and is on staff at Elmbrook Memorial, West Allis Memorial and St Joseph's hospitals in the Milwaukee area.

Richard Shropshire, MD,* of Monona, has retired from his Physicians Plus practice after 37 years of service. Dr Shropshire has also served as a clinical professor in the University of Wisconsin Medical School.

Thomas M. Steed, MD,* medical director of emergency services for Door County Memorial Hospital, recently fulfilled requirements of the American Board of Emergency Medicine. Dr Steed, a 1975 graduate of the Medical College of Wisconsin, completed a residency in internal medicine.He also serves as the medical director for the Door County Emergency Services Department and the Algoma Rescue department.

Ordean Torstenson, MD,* of Madison, has been named Pediatrician of the Year by the Wisconsin Chapter of the American Academy of Pediatrics. Dr Torstenson is a private practice physician at the Dean Clinic. He served as president of the Wisconsin chapter of AAP, and is now the alternate delegate chair for district VI which covers nine states and two Canadian provinces.

Sheldon Wasserman, MD,* is a candidate the 22nd Assembly District seat. Dr Wasserman, an ob-gyn practicing in Milwaukee, is campaigning as a Democrat against freshman legislator Polly Beal. He is a graduate of the Medical College of Wisconsin and has served on the SMS Commission on Governmental Affairs since 1992.

Donald Weinmeister, MD, is a new addition to Group Health Cooperative in Eau Claire. Dr Weinmeister earned his medical degree from the University of Kansas School of Medicine. He completed his residency at the Family Medicine Clinic in Eau Claire and a fellowship in sports medicine in Seattle. Dr Weinmeister is board certified in family and sports medicine.❖

Enjoying the Wisconsin Senior Physicians' Association's June outing at Wisconsin Rapids, 34 participants gathered for a phot at the entrance of the Number 15 Paper Machine Complex of Consolidated papers, Inc.

County society news

Dane. The following members have been accepted by the Dane County Medical Society: Pamela Black, MD; Nancy Charlier, MD; Timothy Gerry, MD; Sally Kraft, MD; Deborah Lynn, MD; Todd VanBlaricom, MD; Theodore Weltzin, MD; Donald Wert, MD; Anne Whitworth, MD; and Anna Windsor, MD.

Green Lake-Waushara. William Thomas Franks, MD, has been accepted into the Green Lake-Waushara County Medical Society.

Milwaukee. The Medical Society of Milwaukee County approved membership for the following physicians: Maqsood Ahmad, MD; Mustafa K. Diktas, MD; Sheldon R. Forman, MD; Charles D. Hugelmeyer, DO; Daniel Jankins, MD; Apollo Y. Leong, MD; Carol M. Meils, MD; Thomas M. Naughton, MD; Yong Hee Rhee, MD; Cathy Cleone Smith, MD; Morton M. Soifer, MD; Eldon J. Swenson, MD; Carmen L. Terlizzi, MD; John D. Wolski, DO; Saleem Aman, MD; Athlene A. Alexis, MD; Mariann Carle, MD; David Keith DeDianous, MD; Francis X. Downey, III, MD; Martin Finck, MD; John Thomas Heinrich, MD; Syed A. Jafri, MD; Stephen Clay Kmecak, MD; Muriel N. Langouet-Astrie, MD; James David McDaniel, MD; Milka Mandich, MD; Conrad Cruz Nievera, Jr., MD; Maria Isabel Periquet, MD; Ravindra S. Sarode, MD; Rita E. Schulz, MD; Alex Zacharias, MD; and Barbara A. Hummel, MD.

Correction

The July *WMJ* list of SMS commission members failed to include Narendra M. Kini, MD, as a member (1994-1995) of the Commission on Health Care Financing and Delivery: 270 E Highland Ave, #847, Milwaukee, WI 53202-6607; (414) 266-2615.❖

Walworth. The Walworth County Medical Society has approved membership for James T. Mulry, MD; and Victor J. Sobolewski, III, MD.❖

WMJ editor attains state and national posts

SMS JOURNAL EDITOR Russell King has been appointed to the American Association of Medical Society Executives Communications Committee. The committee sets the editorial direction for all AAMSE publications and serves as the editorial board for *Medical Executive* magazine.

King was also recently elected to a third term as president of the Council for Wisconsin Writers, Inc., a statewide association promoting awareness of the state's literary heritage and encouraging literary endeavors through an awards program and speakers' referral service for Wisconsin writers.❖

Occupational health guide to be revised

THE OCCUPATIONAL health guide, *Your Body At Work*, will be revised this fall. The guide was developed by the SMS Commission on Environmental and Occupational Health. The last update was completed in 1992. Several new articles will be added to the guide, including information on the Americans with Disabilities Act, OSHA blood-borne pathogens standards, and tuberculosis guidelines. Anyone who is currently using the health guide is encouraged to send in comments about additional items needed to improve the guide. Direct comments or questions to: Lynn Sherman, health policy analyst, State Medical Society, PO Box 1109, Madison, WI 53701.

Obituaries

Schubert, Edward F., MD, died May 23, 1994, in Stevens Point. He was born in Milwaukee April 3, 1924. He graduated from Marquette University Medical School in psychiatry. He served in the US Navy from 1953 to 1954. He was superintendent of the former Central State Hospital for 20 years. He practiced with the Winnebago Mental Health Institute, retiring in 1985. Dr Schubert was a member of the SMS. He is survived by his wife, Shirley, of Westfield; five children, Mark Schubert, Jeffrey Schubert, Judy Schwandt, Cindy Rosol, and Jennifer Harrington; three grandchildren; and a sister.

Jackson, C. Robert, MD, died May 25, 1994. He was born Jan 8, 1928, in St Louis Park, Minn. He served in the US Marine Corps. Dr Jackson graduated from the Thomas Jefferson Medical College in Philadelphia, and went on to practice obstetrics and gynecology at the Madison Medical Center for 30 years, retiring in 1992. He was a member of the SMS and the Dane County Medical Society. He is survived by his wife, Carol (Franklin); three children, Amy Langer (Lance), Carrie Jackson, and Thomas Robert Jackson; his granddaughter, Jordan Jackson Langer; three step-children, Brad (Susan), Pam and Bruce (Franklin); two step-grandchildren, Molly and Chuckie; nieces and a nephew. ❖

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

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Food Allergy	Cytokines
Latex Sensitivity	Beta Agonists
AIDS	Leukotriene Antagonists
Sinusitis	Alternatives to Corticosteroids
AllergicBronchopulmonary Aspergillosis	

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Wesley Burks, MD, University of Arkansas
Kevin Kelly, MD, Medical College of Wisconsin
James Gern, MD, University of Wisconsin
Frank Graziano, MD, University of Wisconsin
David Skoner, MD, University of Pittsburgh
Moses Grossman, MD, University of California - San Francisco
Robert Fisher, MD, Medical College of Wisconsin
Robert Lemanske, Jr, MD, University of Wisconsin
Robert Bush, MD, University of Wisconsin
Jordan Fink, MD, Medical College of Wisconsin

The course is co-sponsored by the Wisconsin Allergy Society, and the Allergy-Immunology Section, Department of Medicine, University of Wisconsin and approved for 8.25 hours of CME credit.

For more information, contact:
Marcus Cohen, MD, (608) 282-8435 or
Robert Bush, MD, (608) 262-7056.

Classified ads

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GENERAL SURGEON/FAMILY PRACTICE/OB-GYN/INTERNAL MEDICINE to join progressive 13-physician group practice. Rural college town 30 miles from St. Paul, MN. New clinic and new hospital. Contact Robert B. Johnson, MD, River Falls, WI 54022. 715-425-6701. 8/94-1/95

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8/94

Medical Meetings-Continuing Medical Education

PRACTICE STRATEGIES IN THE EVALUATION AND MANAGEMENT OF THE GERIATRIC PATIENT, September 8-9, 1994, Holiday Inn Homestead, U.S. Highway 51, Minocqua, Wisconsin. Contact Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449. 1-800-541-2895. 6-8/94

Specialty Societies

September 9-11, 1994: Wisconsin Society of Anesthesiology, Wyndham Hotel, Milwaukee, WI.

September 17-18, 1994: Wisconsin Allergy Society, Concourse Hotel, Madison, WI.

September 17, 1994: Wisconsin Society of Pathologists, The American Club, Kohler, WI.

September 22-24, 1994: Joint meeting Wisconsin Society of Internal Medicine and Wisconsin Chapter: American College of Physicians, Lake Lawn Lodge, Delevan, WI.

September 23-24, 1994: Wisconsin Academy of Ophthalmology, Wisconsin Dells.

September 30, 1994: Wisconsin Chapter: American College of Cardiology, State Medical Society headquarters, Madison, WI.

October 7-8, 1994: Wisconsin Psychiatric Association, Holiday Inn, Appleton, WI.

October 7-9, 1994: Wisconsin Society of Otolaryngology-Head & Neck Surgery, Lake Lawn Lodge, Delevan, WI.

October 14-15, 1994: Wisconsin Radiological Society, Concourse Hotel, Madison, WI.

October 15, 1994: Wisconsin Society of Radiation Oncologists, Concourse Hotel, Madison, WI.

AMA

December 4-7, 1994: Interim House of Delegates, Honolulu.

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Park Nicollet Medical Center 435
Peppino's Restaurant 431
Physicians Insurance Company of Wisconsin ..... IFC
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SMS Insurance Services Inc. 413,BC
Waukesha Memorial Hospital 455
Wisconsin Allergy Society 455

Hospital Medical Staff Section
24th Assembly Meeting
December 1-5, 1994
Sheraton Waikiki Hotel
Honolulu, Hawaii

Representation Education and Networking

Send a representative from your hospital medical staff and physician organization to the 1994 Interim American Medical Association Hospital Medical Staff (AMA-HMSS) Assembly Meeting held on December 1-5 in Honolulu. Aside from participating in the development of AMA policy, representatives will have an opportunity to network with colleagues, dialogue with the AMA Board of Trustees, and hear the latest news and information on health system reform.

With a changing health care environment, broader diversity within the physician population, limited resources, and an overriding need for unity of purpose and action by organized medicine, the AMA has undertaken a study of the Federation.

Federation Consortium Study

The study, involving county, state and specialty societies, the AMA, and other related organizations, intends to uncover useful information for developing ways to increase membership, member participation, and advocacy as well as improve communications, medical society performance, and resource utilization.

Project leaders have asked the AMA-HMSS to participate in the process because it effectively represents grassroot physician concerns. Input from each HMSS representative also will be extremely valuable in defining organized medicine in the future.

The 1994 Interim AMA-HMSS Assembly Meeting Education Program will host the Consortium study. Data collected and analyzed will facilitate the following objectives:

- Identify current and future needs, expectations, and preference of physicians and others for organized medicine;
- Explore membership ideas and options;
- Assess how medical societies relate to each other—including ways to be more supportive, avoid duplication of effort, leverage strengths, and better address weaknesses;
- Discover whether there are better tools/technologies that medical societies can use to communicate with one another and their members; and
- Enable medical societies to work smart in a more focused and purposeful way.

Plan to participate in the Federation Consortium on Friday, December 3 from 2:30 to 5:30 pm in Honolulu, Hawaii. Mahalo!

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September 1994
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Domestic violence in rural areas

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Contents

September 1994 Vol. 93 No. 9

Opinions

461 *President's page*
My campaign slogan: Politics is too important to be left to politicians
by Richard G. Roberts, MD, JD, Madison

464 *EVP report: The view from here*
The sun also rises
by Thomas L. Adams, CAE, Madison

Scientific

467 Adrenal hyperechogenicity in hemolytic uremic syndrome
by Robert G. Wells, MD; John R. Sty, MD; and Ruth A. Brummond, RDMS, RVT, Milwaukee

470 Pedal radiocolloid lymphoscintigraphy in demonstration of a post-surgical lymphatic leak
by Gulay A. Uygur, MD; Gur Akansel, MD; Anna Kolindou, MD; Ali Tan Isitman, MD; Arthur Z. Krasnow, MD; and B. David Collier, MD, Milwaukee

Socioeconomic

473 Issues of domestic violence unique to rural areas
by Cheryl R. Goeckermann; L. Kevin Hamberger, PhD; and Karen Barber, Milwaukee and Elkhorn

480 *Public health*
In situ breast cancer: A local area analysis of Dane County, Wisconsin
by Stacy Herzog, BS; Darren Bush, MA; Patrick Remington, MD, MPH; Mathew Reeves, BVSc, PhD; and Robert Adler, MS, Madison and Atlanta

483 In situ breast cancer correlates with mammography use, Wisconsin: 1980-1992
by Darren S. Bush, MA; Patrick L. Remington, MD, MPH; Mat Reeves, BVSc, PhD; and Jerri Linn Phillips, MA, CTR, Madison and Atlanta

Organizational

487 A glimpse into our past
by Richard D. Sautter, MD, medical editor

487 SMS president appointed to special legislative committee

488 Registration begins for special SMS PO/PHO seminar

491 County society news

491 SMS shares Medicaid reimbursement concerns with state officials

492 Obituaries

493 AMA awards

494 *Wisconsin Medical Journal* instructions to authors

Our cover: "Road with Cypresses," by Vincent van Gogh, 1889. Our cover story begins on page 473.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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President's page

My campaign slogan: Politics is too important to be left to politicians

EVERY OTHER SUMMER, you can hear it coming. It starts as a low rumble and explodes into a deafening roar by October. It begins as something mildly amusing and turns into a snarling fury. It is neither a lion in heat nor intestinal gas; it is a political campaign. With more honking and flapping than Horicon geese, the candidates fill the airwaves to pronounce their positions, protest their opponents' inaccuracies, and proclaim their destinies.

Conventional wisdom has it that physicians are minor players in matters politic. We are said to suffer from the 4 Cs: too Consumed to take time from our busy lives, too Controlling to partake in a team sport like politics, too Cheap to contribute to campaigns, and too Conceited to think that any of this applies to us. I believe the conventional wisdom is, and should be, wrong.

Too consumed

"Politics is my second favorite indoor sport." — JD Kabler, MD

Busy-ness is our business; no occupation demands more time and intense focus than medicine. That aside, we manage to secure time for those things we consider important: family, church, hobbies, organized medicine. A society that is more safe, happy, healthy, humane, educated, fair, and productive is the ultimate aim of politics--few pursuits are more important or more relevant to our responsibilities as physicians and citizens. Political involvement will accommodate as much, or as little, time as we are able or willing to give. It is more informative and entertaining as a participatory, rather than a spectator, sport.

Richard G. Roberts, MD, JD

Too controlling

"I always wanted to get into politics, but I was never light enough to make the team." — Art Buchwald

Politics is people, lots of people. Many candidates, especially for less visible offices, depend on volunteer time to accomplish tasks their cam-

Continued on next page

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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paigns cannot afford to buy. There are always more things to be done in a campaign, then there are people to do them. Each member of the campaign team represents a valuable resource. Contributing a few hours to staff a phone bank, hold a fundraiser or put up posters can be an easy introduction to the intricacies of campaigning.

Too cheap

"Politics has got so expensive, it takes alot just to get beat." — Will Rogers

Time, people, and money are the limiting factors for a campaign. Candidates put their time, egos, reputations, and personal finances on the line when they run. Few endeavors leave people feeling so vulnerable. Even when we cannot give our time, we can give money and encouragement. Money is a symbol of our commitment to the candidate and buys the exposure every candidate requires. As an example, the average member of the public must be exposed to a first-time candidate's name at least three times before that person will recall even having heard the candidate's name.

Too conceited

"Those who are too smart to engage in politics are punished by being governed by those who are dumber." — Plato

The beauty, and the bane, of a democracy is that we get the government we are willing to accept. We may be convinced of the wisdom of a position we hold or the merits of a candidate we support, but our views have not provedthemselves until we have been able to persuade others of their virtues. If we care enough about the issue or candidate, then we must be willing to risk our egos and perspectives as our viewpoints are tossed about in the marketplace of ideas.

Sometimes visionary, most times myopic, politics is an "I" condition. It evokes a range of emotions: indifference, irritation, incredulity, and indignation. It can also inform, inspire, and incite. It converts self-interest into collective action. It induces millions of Americans, people who will wait no longer than one minute for a hamburger, to stand patiently in long lines in schools, town halls, and other public places just for the chance to punch a hole in a card or pull a lever on a machine. A political campaign is the crucible that tests and toughens candidates and commitment. It is rarely tranquil, but it is always important.

Get to know the candidates in your area; attend the WISPAC candidate interviews. Offer your time, ideas, and money as best you can. Successful candidates remember those who stood by them in uncertain times. If you want to be heard while they govern, you need to be known while they campaign.❖

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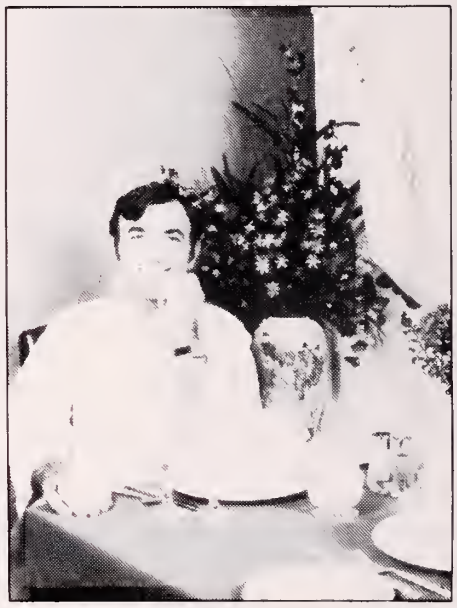

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EVP report: The view from here
The sun also rises

I WAS DRIVING FROM Madison to Milwaukee to talk to a group of medical students, and I was in a foul mood. My mood had nothing to do with the students, the speech or the drive. It had everything to do with the state of health system reform. It appeared that day (and still does now) that the opportunity to make genuinely meaningful improvements to the world's best health care system and benefit tens of millions of Americans had been lost--sacrificed for the sake of special interest greed and partisan power struggles.

I've never minded mistakes, missed opportunities, or even errors in judgment. They are a part of life. Anyone who isn't making mistakes isn't trying to accomplish anything. Being imperfect creatures, we sometimes miss the signs or misread the signals and miss chances to achieve goals. And, our ability to interpret data being as imperfect as our ability to receive data from our environment, we sometimes make poor choices. It goes with the territory; it's called being human.

That's OK. What's not OK is to the ignore data, to deny the evidence, or to choose to let an opportunity pass for the sake of short-term over long-term goals, for the good of special interests over the nation's general health, or for personal or political gain over the needs of the populace. So I was not a happy camper as I motored toward Wisconsin's East Coast.

Worse, the failure to reform led me to worry about the future of the profession. Our adversaries loomed large in my mind, and the horizon seemed darkened by their shadows. I felt a certain affinity for medical writers at the turn of the century who thought that "...penury, want, and even starvation, stare the whole body of medical men in the face..." I wasn't about to make that leap, but I wasn't feeling very optimistic, either.

Thomas L. Adams, CAE

Given my frame of mind, I was not prepared for what I found at the Medical College of Wisconsin. I expected to find students in fear for their futures--at best students struggling against the tide with grim determination. I am happy to report that the medical students of MCW made me ashamed of myself.

These students, these physicians of tomorrow, feel good about the future of medicine. They literally made the room come alive with their energy, their enthusiasm, and their obvious desire to make a difference with their lives.

These students reminded me of a *WMJ* editorial I once read, so when I returned to the office I looked it up. The year was 1904 and the general mood of medicine was about as pessimistic as it is in 1994. Dr Arthur Patek, the journal editor, wrote this gentle reprimand:

"Let us rid ourselves of the delusion that there was a golden age; that things were better in the days of our fathers (more or less remote); that the skies are bluer in Italy than elsewhere; that there were 'good old times'; that our profession is the most undesirable, most abused, most traduced, most uncomfortable and thankless avocation in the world.

"These delusions are the outgrowth of an exaggerated respect for the past... It is far more satisfactory to view the facts of history through unstained glass and see them as they really are. We are thus enabled to take a more sanguine and optimistic view and recognize the fact that at no time in the history of the human race have there been greater opportunities for young medical men and women than the present ... for doing good to one's fellow man..."

Without having read these words --now fading from their musty, yellowing pages in an SMS subterranean vault--these students are liv-

ing in the spirit of these words. They are not worried about making money. They are not worked up about tort reform. What few worries they have are very different, in topic and in tenor, from the concerns of the most vocal, if not the majority, of practicing physicians.

I think we can all learn from them. They look to the horizon and see not forces arrayed against them, but countless opportunities to heal. They see the passion, joy, and beauty of a physician's life cresting the hill as a radiant sunrise--just as you did when the face in your mirror had fewer lines.

Let's accept the inspiration; let's embrace their example. As the SMS works on its strategic plan, as we plot our course for the coming months, as we look to the years ahead, let's renew our faith in the men and women of this profession. Let's turn from the setting sun and, instead, see it rising.

* * *

Last month, in writing about the level of insanity reached by the would-be reformers in Washington, DC, I penned the line "Things got so crazy that the AMA Board of Trustees voted to back a bill that was still being drafted." Two weeks ago, I sat down with Dr James Todd, the AMA executive vice-president, on his recent visit to Wisconsin who had read the article. Dr Todd reminded me that the AMA was so deeply involved in writing the bill in question that to wait for a final draft before endorsing it would have foolishly wasted precious time in the political struggle. Extreme circumstances demand extreme actions, which the AMA provided, but not at the risk of being irresponsible. Thanks Dr Todd.❖

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Adrenal hyperechogenicity in hemolytic uremic syndrome

Robert G. Wells, MD; John R. Sty, MD; and Ruth A. Brummond, RDMS, RVT, Milwaukee

Hemolytic uremic syndrome is characterized by an abrupt onset of a microangiopathy, thrombocytopenia, hemolytic anemia and renal failure. These abnormalities present in varying degrees. The vascular abnormalities include endothelial swelling and thrombus formation. The kidney is the major target of involvement, although intestines, lung and brain may also be affected. It is considered a disease of the infant, although it occurs in older children and adults as a component of thrombotic thrombocytopenic purpura. We present the sonographic findings of adrenal involvement in a child with hemolytic uremic syndrome, which seems to be a rare occurrence. The patient developed adrenal insufficiency during the acute phase of the disease. *Wis Med J.1994;93(9):467-468.*

Case report

This 25-month-old child had fever, vomiting, bloody diarrhea and abdominal discomfort. The child was critically ill with pallor, irritability, hypertension and oliguria. The diagnosis of hemolytic uremic syndrome was established with laboratory studies. Adrenal insufficiency developed. The child eventually died because of central nervous system complications. Sonography of the abdomen demonstrated normal solid organs, with the exception of the kidneys and adrenals. The kidneys were of normal size, and noticeable increased echogenicity was visible. This was most prominent in the glomerular and subcortical regions. In addition, the adrenals were slightly enlarged, but markedly echogenic (Figure). These findings were most marked in the medullary portions of the adrenals.

Discussion

Hemolytic uremic syndrome (HUS) is a disease of unknown etiology that usually occurs in children between the ages of 4 months and 4 years. There is often a prodrome of gastroenteritis or respiratory tract infection. The pathologic manifestations of the disease are those of a

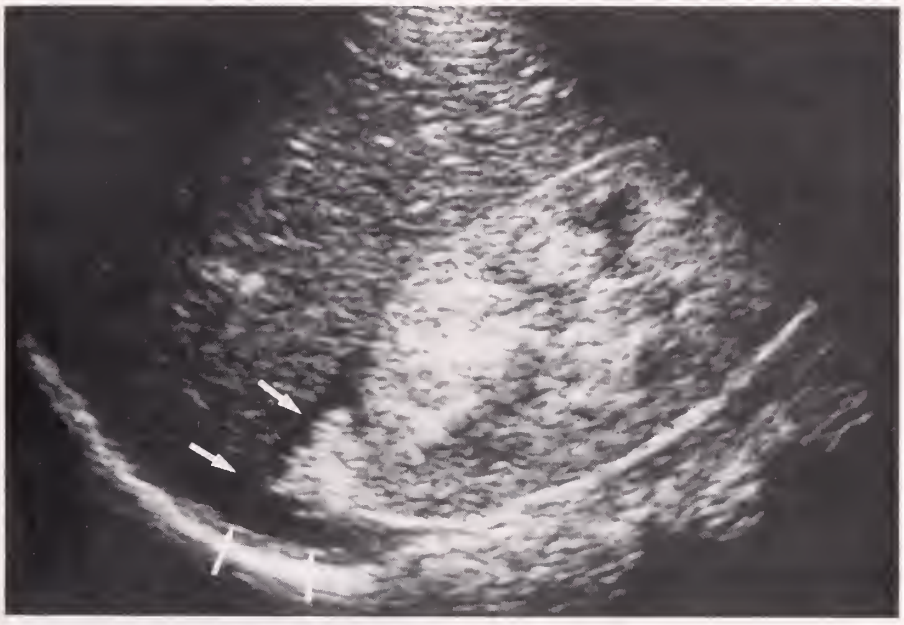

Fig.--Longitudinal renal sonogram. The examination shows increased echogenicity in the glomerular and subcortical regions of the kidneys. Note slightly enlarged, densely echogenic medullaly regions of the adrenal. The overlying adrenal cortex is hypoechoic in comparison.

From the Department of Radiology at the Children's Hospital of Wisconsin. Reprint requests to: Robert G. Wells, MD, Children's Hospital of Wisconsin, 9000 W Wisconsin Ave, MS 721, Milwaukee, WI 53226. Copyright 1994 by the State Medical Society of Wisconsin.

microangiopathy, associated with an angiitis and the formation of platelet thrombi. The clinical manifestations of the disease are, in most cases, dominated by renal involvement. There is, however, probably some degree of multisystem involvement in all cases, either pathologically or clinically. Organ systems that may clinically manifest involvement with HUS in addition to the kidneys, include the brain, gastrointestinal tract, pancreas, heart and liver.

Sonography is useful in hemolytic uremic syndrome for estimating renal size and assessing changes in the renal parenchyma. Early in the disease, sonography is normal or shows nonspecific nephromegaly. Eventually, abnormally increased echogenicity is visible, usually being most prominent in the glomerular and subcortical regions. This abnormality appears to be the result of calcification and collagen deposition. Depending on the severity and duration of the disease, sonography can be used to follow the renal findings sequentially.[1]

The microangiopathy that occurs in the kidneys in hemolytic uremic syndrome is attributed to an altered physiology of the glomerular epithelium. Histologic glomerular findings include congestion, cell proliferation, collapse of capillary walls, glomerular infarction, fibrin thrombi, and the presence of erythrocytic fragments. The abnormal endothelium traps fibrin, platelets, and fragments of adjacent cells.

Thrombosis and endothelial damage occur in arterials and small arteries.[2] Alterations in renal arterial flow in patients with hemolytic uremic syndrome have been documented with doppler studies. With severe renal involvement, intrarenal arterial flow may not be detectable, or systolic doppler signals are seen with absent or reversed diastolic doppler signals.[3,4] Doppler studies were not available in the presented case.

Although, pathologic examination of the adrenals was not available in the presented case, the same pathophysiologic events probably took place as in other involved organs, ie microangiopathy, ischemia, hemorrhage and edema. The finding of abnormal adrenals with hemolytic uremic syndrome is not common and in the last 52 hospitalized children studied at our institution with hemolytic uremic syndrome and typical sonographic renal findings, only one case of marked adrenal abnormality was seen. Adrenal involvement with sonographic abnormality has not been reported in the literature. We are not aware of this combination of findings in other systemic diseases that affect the kidneys, such as Goodpasture syndrome, systemic lupus erythematosus, mixed connective tissue disorders, collagen disease, lysosome storage disease and infiltrative abnormalities such as leukemia or lymphoma. In addition, the sonographicly abnormal adrenals correlated with adrenal insufficiency. Follow-up studies were not performed because the patient died of CNS complications.

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Pedal radiocolloid lymphoscintigraphy in demonstration of a post-surgical lymphatic leak

Gulay A. Uygur, MD; Gur Akansel, MD; Anna Kolindou, MD; Ali Tan Isitman, MD; Arthur Z. Krasnow, MD; and B. David Collier, MD, Milwaukee

Radiocolloid lymphoscintigraphy is a very effective diagnostic procedure for dynamic evaluation of lymphatic flow. In this case report, the use of radiocolloid lymphoscintigraphy in detection of a post-surgical lymphatic leak is presented. Dynamic pedal lymphoscintigraphy with Tc 99m-antimony trisulfide colloid clearly demonstrated the site of the leak. *Wis Med J.1994;93(9):470-472.*

THE USEFULNESS OF radiocolloid lymphoscintigraphy (RLS) has been well established in the evaluation of lymph nodes and lymphatic flow patterns in patients with breast cancer[1] and genitourinary cancer,[2] as well as malignant melanoma.[3] RLS has also been very useful diagnostic tool in differentiating lymphedema from other causes of extremity edema.[4-6] This test can provide information regarding lymphoceles,[7,8] surgical lymphatic interruptions,[9] and lymphocutaneous fistulas.[10]

Recently introduced microsurgical techniques can now be used to anastomose lymphatic vessels to veins. In this clinical setting, RLS not only identifies patent lymph channels but also demonstrates lymphatic flow through lymphovenous anastomoses.[11]

The scientific literature demonstrates that when compared to invasive x-ray or angiography, radionuclide lymphoscintigraphy has several definite advantages. Whereas x-ray lymphangiography requires local anesthesia, a skin incision, and cannulation of lymphatic channels, the nuclear medicine technique is non-invasive, requiring only intradermal injection. Unlike the forced injection of contrast performed with the radiographic technique, the nuclear medicine procedure accurately depicts lymphatic flow in both normal and morbid states. Finally, the nuclear medicine procedure has greater sensitivity allowing depiction of small lymphatic channels and lymphatic leaks.[12]

We report a case of post-surgical lymphatic leak documented by RLS.

Case report

A 52-year-old man was admitted to the hospital with a large swollen, tender and erythematous mass in his left groin, which was initially thought to be an abscess. The patient had undergone a surgical excision of a large left inguinal lipoma 3 weeks prior to his admission.

On physical examination, there was a large fluctuant mass in the left upper thigh region anteriorly with surrounding erythema, known tenderness and induration. During surgical exploration, a left groin lymphocele was found, a drain was placed for suction and compressive dressings were applied.

The patient left the hospital against medical advice and returned

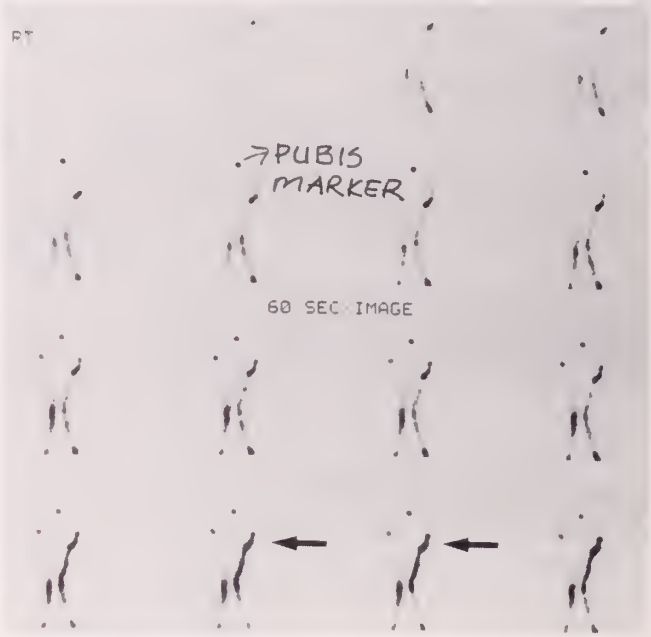

Fig 1.--Dynamic images of the lower extremities at 60 sec/frame obtained following the intradermal injection of Tc-99m antimony trisulfide colloid in both feet show a normal ascent of radiotracer through the lymphatic channels of the right leg. On the left side there is prominence of activity in the left groin (arrow).

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the next day with left leg swelling along with drainage of clear yellow fluid from his left groin.

Another surgical exploration of the left groin region revealed three areas of open draining lymphatic vessels which were ligated. The left leg swelling persisted following this third surgery. A Doppler ultrasound was performed to exclude deep venous thrombosis. It was difficult to determine whether the edema was due to surgical trauma or further lymphatic leakage. Pedal lymphoscintigraphy was performed to detect any ongoing lymphatic leakage.

Following simultaneous 1.0 MCi intradermal injections of Tc 99m antimony trisulfide colloid (Tc-99m ATC) into the web spaces of the first and second toes of both feet, the injection sites were manually pumped and dynamic images over the lower extremities obtained. Delayed static images were obtained at 45 and 70 minutes. The dynamic images showed prominence of radiotracer activity in the left groin (Fig 1), but the 45 and 70 minute delayed images clearly showed extravasation of radiotracer in the left groin (Fig 2).

Based on the results of lymphoscintigraphy, plans for more expensive and invasive diagnostic testing including invasive radiographic lymphangiography and magnetic resonance were cancelled. Further surgical exploration was not performed and the patient was treated conservatively. Over the next 3 weeks there was lessening of groin swelling and leg edema indicating a spontaneous return of adequate lymphatic drainage.

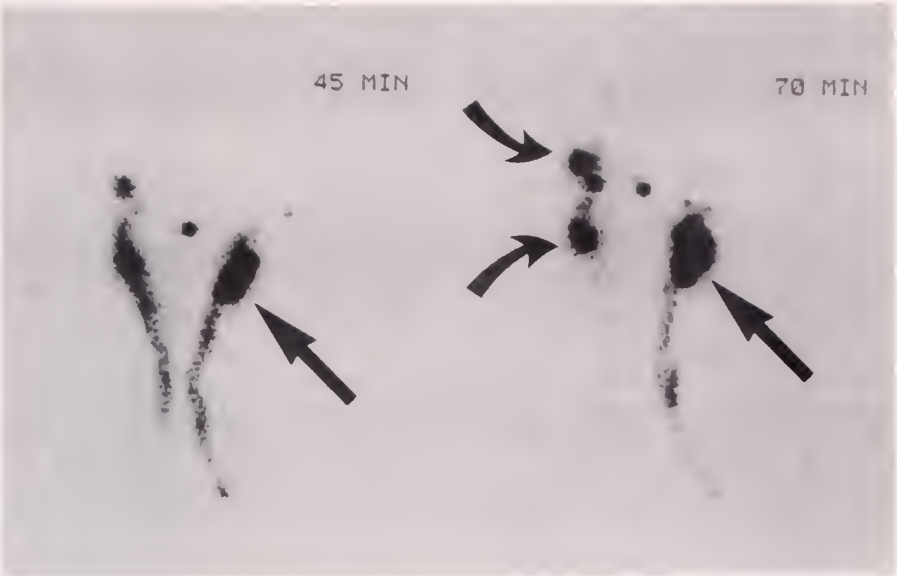

Fig 2.--Delayed static images obtained at 45 and 70 minutes show extravasation of radiotracer into the soft tissues of the left groin (straight arrows). Normal activity is seen in the right inguinal lymph nodes on the 70 minute image (curved arrow).

Discussion

Lymphedema can be a primary condition (eg, lymphatic aplasia, hypoplasia, or lymphangiectasis) but is more commonly secondary. Radiation therapy, surgical resection of lymph nodes, inadvertent surgical injury to the lymphatic channels and recurrent infections may disrupt lymphatic flow and cause secondary lymphedema.[13] Lymphocutaneous fistula is among the complications of lymphedema. Clinically, local swelling and open lymphatic drainage suggest the possibility of a lymphatic leak.

In majority of the cases lymphedema is diagnosed with clinical findings and exclusion of venous or systemic causes. Imaging studies provide objective confirmation of the diagnosis, evidence of the site of lymphatic malfunction, objective treatment follow-up.

Frequently, as in our reported case, RLS is the most effective technique for showing the lymphatic flow pattern and detecting the site of the lymphatic leak. The complementary role of ultrasound, computed tomography and magnetic resonance involves imaging of lymphoceles and other associated soft tissue pathology.

Lymphatic obstruction and leaks have traditionally been imaged using radiographic lymphangiography. Although a useful tool in evaluating large proximal lymphatic vessels, lymphangiography is a tedious procedure requiring incision of the skin, cannulation of the lymph vessels to administer the contrast agent and has been associated with such complications as infection and very rarely pulmonary oil embolism.[14] In addition, lymphangiographic contrast may actually irritate and cause further obstruction in already abnormal lymphatics.

RLS when first introduced in 1953 employed interstitial injections of radioactive gold (Au-198) colloid.[15] Despite good lymphatic uptake from the injection site and adequate transit, this technique delivered high radiation doses to the patient. Tc-99m labeled agents have significant advantages over Au-198 in terms of radiation dose and energy characteristics. The first Tc-labeled agent used for lymphoscintigraphy was Tc-99m sulfur colloid, which has a relatively large particle size. With the introduction of smaller sized colloid particles such as Tc- 99m ATC, better visualization of the lymphatic channels and lower radiation exposure was possible. Different radiopharmaceuticals have been used for lymphoscintigraphy including other Tc-99m labeled col-

loids and macromolecules such as Tc-99m human serum albumin with good visualization of lymph nodes and lymphatics.[16]

We conclude that when there is clinical suspicion of a lymphatic leak, RLS should be considered. Lymphatic leaks may be clearly imaged by this physiological imaging modality.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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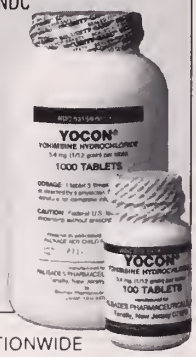

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Issues of domestic violence unique to rural areas

Cheryl R. Goeckermann; L. Kevin Hamberger, PhD; and Karen Barber, Milwaukee and Elkhorn

Domestic violence against women occurs within and across all socioeconomic, demographic, and geographic regions of the United States. Many of the dynamics related to domestic violence, and which trap women in violent relationships, also cross these boundaries. These dynamics include societal and community attitudes toward violence, isolation, fear of exposure, lack of resources to facilitate leaving a violent relationship, and lack of sufficient accessible services for victims of violence. This paper highlights that these and other issues of domestic violence are intensified in rural settings. As such, physicians working in rural areas may face unique challenges in helping battered women. Such challenges will require solutions based on knowledge of specific rural location. A number of rural-based solutions for physician interventions with rural battered women are discussed. *Wis Med J.1994;93(9):473-479.*

In recent years, there has been increasing awareness about the problem of domestic violence among patients seeking medical care. This increased visibility of domestic violence in medical settings is due primarily to two factors. First, a number of studies have been published that show high incidence and prevalence rates of battering victims seeking medical services, but extremely low rates of detection by medical practitioners.[1,2] Second, the issue of domestic violence in medical settings has gained visibility due to pronouncements by Surgeons General Koop[3] and Novello[4] that it is a national public health problem requiring the active involvement of all medical professionals to effectively intervene.

Increased attention to the problem of partner violence in medical settings has resulted in a number of programs designed to train physicians and medical students to identify and help victims of partner violence.[5-7] In addition, domestic violence or abuse programs have expanded to incorporate training of medical personnel.[8] Many new studies have continued to reinforce the idea that domestic violence is a pervasive, national problem requiring the involvement of medical practitioners to develop solutions.

"Battering appears to be the single most common cause of injury to women--more common than automobile accidents, muggings and rapes combined."[9]

Lifetime prevalence rates of woman abuse are at least 20%[10] and it has been shown that between 20% and 35% of women entering an emergency room are victims of domestic violence. To illustratethe need for physicians to develop skills at identifying and helping battery victims, one recent study involving nearly 400 women in outpatient primary care demonstrated that on a routine visit, 6.5% of women were asked about relationship problems by their physician, 2% were asked about verbal abuse, and 1.7% were asked about physical assault.[2]

Studies in emergency medicine have also estimated that only about 10% of battered women seeking services are appropriately identified.

Another study found that battered women consistently rated physicians as the least effective at helping them, compared to several other helping professions, including social services, clergy and attorneys.[11]

While beyond the scope of this paper, the interested reader is referred to a number of other sources for information on skills training for identifying and helping violence victims.[2,12-14]

Most of the research on incidence

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Continued from preceding page
and prevalence of battering has been done in urban areas. This research bias could lead to the misconception among physicians and the public that the problem of domestic violence is one of lower socioeconomic classes in urban areas. Further, rural life is generally perceived as "healthier and safer" when compared to city life.[15] Studies have been conducted, however, that show domestic violence crosses all boundaries: racial, socioeconomic class, marital status, and sexual orientation, as well as urban and rural locations.[16]

Information about domestic violence is just as relevant for physicians practicing in rural locations as it is for those in the inner city. In fact, there are many issues and dynamics which are unique to partner violence in rural areas. These dynamics and issues may function to intensify and complicate the problem of stopping violence and seeking safety for citizens of rural areas. Physicians need to be aware of these factors when inquiring and addressing the issue of domestic violence with their rural patients. Attention to these unique dynamics will enable physicians to be more effective in helping rural battered women in their practices.

Issues intensified by rural life

Attitudes. Perhaps the most important set of issues that may influence effective intervention with rural battered women is one of attitudes. Already mentioned is the idea that country living is viewed as "healthy and safe" compared to city living, which is often thought of as "violent and dangerous." Rural families are thought to be more wholesome and intact. The idea of violence occurring in homes is often met with disbelief and resistance. Studies have shown urban areas to have higher homicide rates than non-urban areas.[17] It does not follow, however, that rural areas are immune from the problems of partner violence. Hence, although research has shown that physicians, generally, often do not suspect that abuse occurs in the lives of their patients, rural physicians may need to be especially cognizant of this potential bias, and if present, change it to an understanding of the reality of violence in the lives of many of their female patients.

A second prominent attitude is one of sex role stereotyping. Sex role stereotyping involves rigidly ascribing specific roles to men and women strictly on the basis of gender.[18] For example, the woman is to be subservient to her husband and needs to obey him. The man is to be in control of "his woman." The woman's role is to preserve the integrity of the family. The man's role is to be strong and unemotional. Such beliefs pervade US culture, but may be uniquely experienced in rural areas where work roles may be more clearly defined.

Not only do many women hold these beliefs, themselves, but neighbors and relatives may be less supportive and empathetic of her situation due to these views. They may encourage her to "be a better wife," or remind her that she "made her bed and now must lie in it." Such attitudes also pervade the social networks of urban battered women. As discussed above, however, in rural areas with limited resources, expression of such attitudes by those in a position to help may intensify the isolation and entrapment of battered women.

Isolation. Another important barrier to rural battered women seeking and finding safety for themselves and their children is the isolation inherent in rural living. All battered women suffer some degree of psychological as well as physical isolation. Typically, this isolation is imposed by their partners. The "secret" nature of partner violence is, in part, brought about by terror and fear of retaliation for reporting violence even if there is no explicit prohibition from the abusive partner. Many battered women are explicitly threatened with violence or death if they reach outside their relationship for help.

Women in rural locations have many added facets of physical isolation. Often there are no neighbors nearby to hear a woman's screams. There is also nowhere close for the woman to run to for help. It is not uncommon for a woman to have to walk several miles to reach assistance. To make such a trek, she may have to consider leaving without her children—often an unacceptable proposition.

Many rural homes do not have a telephone. Where there are phones, some rural areas still have party lines where any neighbor could listen to the call, or it is a long distance call to the nearest crisis program, which will then show up on the telephone bill. Many rural crisis programs do not have a toll-free number.

Even casual contacts with neighbors, which would facilitate development of social supports, is made difficult by the physical distances between neighbors. Women cannot easily meet with their friends. This is due, in part, to the lack of proximity and places to go for private conversations. The lack of social support may also be imposed by the abusive partner. Abusive partners often deny women the opportunity to maintain friendships and contacts with relatives. Such denial is easily reinforced in physically isolated areas.

Sometimes family and friends add to the isolation. This is done through the reinforcement of stereotyped sex roles, eg, "Stand by your man," or by holding the woman responsible for her victimization, eg, "Try to be a better wife."

There is often a lack of transportation. Many victims do not have access to a vehicle and public transportation does not exist in rural areas. Frequently, lack of access to

transportation is imposed by the abusive partner. If the couple owns a vehicle, the abuser drives it. Even where there are multiple vehicles, extra vehicles are typically "disabled" or their odometers are carefully monitored by the abuser. Further, the physical isolation of rural areas also complicates efforts of service agencies for battered women, as discussed below.

Lack of programs. A related obstacle faced by women in remote areas is the relative lack of assistance and public programs available to them. Law enforcement officials frequently have to cover large areas with few officers. This may result in them taking more than an hour to respond to a call for intervention. If the batterer knows that the call has been placed, this hour can be deadly.

Domestic abuse programs do not always exist in the immediate area. A rural program for battered women may serve multiple counties, covering hundreds of square miles. They may lack sufficient full-time, trained personnel to staff the program for 24 hours. The program may not include provision of shelter services. The problems of distance, staffing, and programs constitute significant challenges for battered women, and physicians who would help them.

Lack of privacy. Another barrier facing women is the lack of privacy that can exist in rural locations. Small towns lack anonymity. If a woman discloses what is happening to her or calls for help, she risks having many people in the community finding out. Neighbors often have police scanners. Friends and acquaintances may be on the police force. Arrests are published in the local newspaper. Finally, women are frequently afraid to use available services (medical or social) because friends and relatives may work in the hospital or building, or may see them in the waiting room. Again, this may lead to fear of (and actual) inappropriate disclosure of her plight.

The idea that her situation will become common knowledge and dinner discussion, or that her partner may punish her for seeking help, often intensifies the victim's feelings of fear, shame, and humiliation. As a result, she may choose to not make her abuse known.

A woman is often afraid to dis-

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close what is happening for fear no one will believe her. The batterer is often seen as a pillar of society--an elder in the church or a little league coach. People in the community, including physicians, may find it hard to believe that violence is occurring in that particular household. The victim's call for help may, therefore, bring more shame and ridicule and may even alienate her from friends and family. This leads to further isolation, as noted above.

In addition to her fear of not being believed, many battered women experience a strong "need to protect the batterer" in rural areas. In addition to the publicity issue discussed above, in a rural area her partner could lose his job, his friends, his status, etc. Her partner and others may pressure her to "drop it" and tell her that she is "destroying" the lives of her partner and family. The resultant guilt and intimidation may motivate her to not reach out for help.

Finally, there are a few factors which are typical of rural life that can further complicate medical interventions for battering. These include the presence of hunting weapons. Hunting weapons and loaded guns are usually common and accepted in rural households. Batterers often use firearms to terrify and threaten victims. Such threats may be quite overt, as when the batterer points a weapon at his partner and threatens to shoot her. Threats can also be subtle, including picking up a gun and "cleaning" it during an argument, or by simply having many guns freely available around the house.

Another complication is the seasonal nature of many rural-based occupations, such as farming or businesses related to agriculture. Such occupations involve extended periods of layoff, and thus time at home. Bad weather can intensify the effects of physical isolation and time spent together. Telephones get disconnected, roads aren't plowed, and the partner often cannot go to work. This creates increased opportunity for tension to build and battering to occur.

Because of the extra time at home during prolonged layoffs, drinking is likely to occur in the home. Although alcohol is generally not viewed as causing domestic violence, it often adds to family tensions that can escalate the danger.

Once a woman decides to leave and overcomes many of the above problems, she runs into a whole new set of problems unique to living in remote locations. These factors make it difficult for battered women to leave a violent partner and begin a violence-free life. For example, there is a lack of affordable housing for single mothers. Employment may be hard to find, especially if some people in the town do not believe her accusations and doubt her integrity. Quality, affordable child care may not be available.

Finally, many women feel if they decide to leave their partner, they must leave the whole town and make a fresh start. But often this town is all they know. They grew up there, all of their family and friends live there, and there is tremendous fear of moving away to the "big" city (even a city of 20,000). This fear alone often paralyzes women from taking action.

Rural services in Wisconsin

Thirty-three rural domestic violence programs serve 55 rural counties in Wisconsin (as defined by the Demographic Services Center, Wisconsin Department of Administration). Of these 33 programs, 19 have associated shelters. A survey sent to 20 rural programs (15 shelter programs and 5 non-shelter programs) reveals some of the common daily struggles they face.[19] See the table for a summary. The challenges faced by rural domestic violence programs are similar to many of those described above.

The rural physician's role

Because of the unique nature of rural living, physicians who treat battered women from such areas also face unique challenges in their efforts to help. There are many things rural physicians can do to help their battered patients.

Knowledge of local resources. Physicians must become familiar with existing area resources for battered women and their children. If there is no domestic abuse program in the immediate area, physicians must be aware of the program location. Even where the shelter or advocacy program is located far from the physician's office, many rural domestic violence programs develop networks of volunteers and safe-houses in their service areas.[20] Physicians should also know how to gain access to these networks, and understand the services available through them.

Active patient involvement. Because services may be difficult for battered women to find and use, as discussed above, physicians will also have to play a more active role in providing ongoing and follow-up care to battered women. This includes a greater degree of supportive counseling, problem solving and safety planning than may be necessary in urban areas.

In rural areas, the physician may literally be the battered woman's primary support resource for an extended period until the domestic violence program is able to become involved, or between trips to the nearest support program. Such activities go beyond merely informing a battered woman of available resources or providing phone numbers and pamphlets on domestic violence.

Instead, physicians will need to dedicate time to listen to their patients, help them assess their situation in detail and conduct ongoing problem-solving and safety plan-

ning counseling services. Because such activities are potentially time consuming in a busy primary care practice, medical support staff--such as nurses or medical assistants--could be trained to provide many of them. Such training would include understanding the dynamics of domestic violence and ethical issues involved in caring for victims of violence. Arrangements can be made with the area domestic violence program to provide staff to consult or conduct the clinic-based programs as well.

In addition to providing individual counseling, support groups can be developed and conducted in the primary care clinic or health center. One concern about starting clinic-based support programs for battered women would be that their abusive partners would prohibit their attendance. Such groups, however, need not be advertised as domestic violence programs, but as women's issues programs as part of clinic outreach and patient education.

Maintaining confidentiality. Because privacy is a key issue in rural areas, as noted above, physicians who treat battered victims are challenged to take particular care to maintain confidentiality. Because staff will be involved in the battered woman's care, they will also need education in the special requirements for maintaining the confidentiality of abuse victims.

Specific disclosure of information about a person's victimization should come only after discussion and receipt of signed informed consent of the patient. Discussion of patients' status among office staff must be restricted to what is relevant to patient care. Under no circumstances should the victim's partner be notified without clear consent of the battered patient, and then only after appropriate safety planning has been conducted. The reason for this caveat is that the abusive partner usually has a vested interest in maintaining the violence as a secret. Realizing that his secret has been disclosed can result in further violence toward the victim.

Using ancillary resources. Resources for help ln rural areas are often limited. It can be tempting to refer a battered woman and her abusive partner for couples counseling to a local mental health agency.

Under most circumstances, couples counseling is contraindicated in cases of partner violence.[7] The basis of the contraindication is the relative lack of training in violence issues exhibited by many marriage and family therapists.[21] Also, couples counseling endangers battered women by creating a sense of safety and demand to disclose delicate information and family secrets that the batterer may not want disclosed. Such disclosures can result in further violence outside the counseling session.

Instead of referral for couples counseling, the battered woman should be counselled alone. The types of counseling described above are usually a good start until she can access a battered woman's support program. If she exhibits a need for

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Service characteristics of rural Wisconsin domestic violence programs.

Days of care provided:
1990: 12,321 (11 prgms. reporting)
1991: 14,662

Has the program had to refuse services?
Yes: 7
No: 11

Distance traveled to receive services:
Range: 15-150 miles
Average: 59 miles

Clients without telephone service:
Range: 2% - 80%

Programs with 1-800 numbers:
Yes: 10
No: 10

Clients without transportatlon:
Range: 5% - 90%
Averaqe: 56%

Proqrams with a transitional livinq program:
Yes: 4
No: 16

Proqrams with a children's proqram:
Yes: 16
No: 4

Proqrams experi-encing fundinq decreases in 1992:
Yes: 9 (Average 34% decrease)
No: 8

Continued from preceding page
professional counseling, she should be referred individually. If possible, any therapist for battered women should be known to have demonstrated expertise or understanding of domestic violence issues.

Documentation. All physicians should document their findings and clinical activities with battered patients. Because rural physicians are likely to play a more active role in helping such patients, documentation is even more important. As noted above, rural physicians may be the primary source of support for a battered woman over an extended period of time until other domestic violence programming can be brought to bear. Therefore, documenting reports of violence, injuries, judgments of dangerousness, safety planning, and consultation with domestic violence program specialists may be the only official record of a battered woman's situation. Such a record can be of considerable help in court cases involving custody and visitation, as well as criminal proceedings.

Community influence. Because physicians are often prominent citizens in rural areas, they can have considerable effect on community organizing around health care issues.

One such area with considerable potential is domestic violence. At the clinic and hospital levels, domestic violence committees can be developed. These committees function to educate health care professionals in identification and intervention skills and to develop and monitor hospital and clinic policies on domestic violence interventions. Physicians can collaborate with area domestic violence programs to develop such hospital- or clinic-based policies and programs.

On a broader scale, physicians can also participate in community interventions. This can include joining an existing community task force on domestic violence, or advocating for the initiation of such a body. Such task forces typically include law enforcement, criminal justice, domestic violence advocates, social service agencies, clergy, and the schools. Working with such a group demonstrates to the physician that domestic violence is a community problem that physicians are not expected to confront alone—a major reason provided by many physicians for not addressing the problem with their patients.[22]

Finally, physicians can establish their own offices or clinics as "safe havens" against violence. This can be accomplished by providing clear evidence in the clinic that family safety is valued. Such values are communicated through the availability of patient education materials, posters, and information about local resources for help and safety. The value of family peace is also communicated by the willingness of physician and staff to respond with empathy and certainty to victims of violence when they present to the office.

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Summary

Many aspects of rural life are different than city life. Women residing in these areas face significant barriers when coping with and trying to escape domestic violence. Compared to physicians in urban areas, physicians in rural areas play a different, and in some ways an even more crucial, link between victimized women and available resources, because rural resources tend to be more limited, less publicized, and more spread out than in urban areas. Physicians need to be aware of the programs and help available in their specific location so they are able to direct patients once they are identified as battered women. Physicians also need to be aware of their unique roles in helping these women, in-

cluding advocacy, counseling, and community involvement.

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In situ breast cancer: A local area analysis of Dane County, Wisconsin

Stacy Herzog, BS; Darren Bush, MA; Patrick Remington, MD, MPH; Mathew Reeves, BVSc, PhD; and Robert Adler, MS, Madison and Atlanta

THE RECENT INCREASE in mammographic screening in Wisconsin and the nation has resulted in an increase in the incidence of breast cancer and a shift toward earlier detection.[1-3] The percentage of in situ diagnoses of breast cancer in Wisconsin increased dramatically, from 1980 to 1992.[4]

It is believed that this increase in early stage breast cancer is a direct result of the increased use of mammography screening. Therefore, we hypothesized that areas with a greater percentage of in situ breast cancer are areas with more active screening mammography. The purpose of this study was to analyze in situ breast cancer trends in Dane county and use the results to plan mammography screening initiatives in the region.

The public health column is not reviewed by the *WMJ* Editorial Board. Herzog is a graduate student in the University of Wisconsin Programs in Health Management currently interning at the Division of Health. Bush is the surveillance coordinator for the Wisconsin Women's Cancer Control Program. Dr Remington is the chief medical officer for Chronic Disease Control, Bureau of Public Health, Wisconsin Division of Health. Dr Reeves is an Epidemic Intelligence Service Officer with the Centers for Disease Control and Prevention in Atlanta. Adler is a research analyst with the Center for Health Statistics, Wisconsin Division of Health. Reprint requests to: Patrick Remington, MD, Wisconsin Division of Health, 1400 E Washington Ave, Madison, WI 53703-3041. Copyright 1994 by the State Medical Society of Wisconsin.

Methods

Data from 1,037 cases of breast cancer diagnosed in residents of Dane County during the 5-year period 1988-1992 was obtained from the Center for Health Statistics, Cancer Reporting System (a statewide, mandatory cancer reporting registry). The number of in situ cancers for each census tract in Dane county was calculated. Due to the small number of cases in some of the census tracts, it was necessary to group the tracts into geographical regions to produce an acceptable number of cases for analysis (ie, more than 40 per region).

The following 11 regions were created on the basis of geographic location and population: West Rural Dane County, North Rural Dane County, Southeast Rural Dane County, South Dane County, Middleton, Far West Madison, West Madison, Central Madison, North Madison, Northeast Madison, and

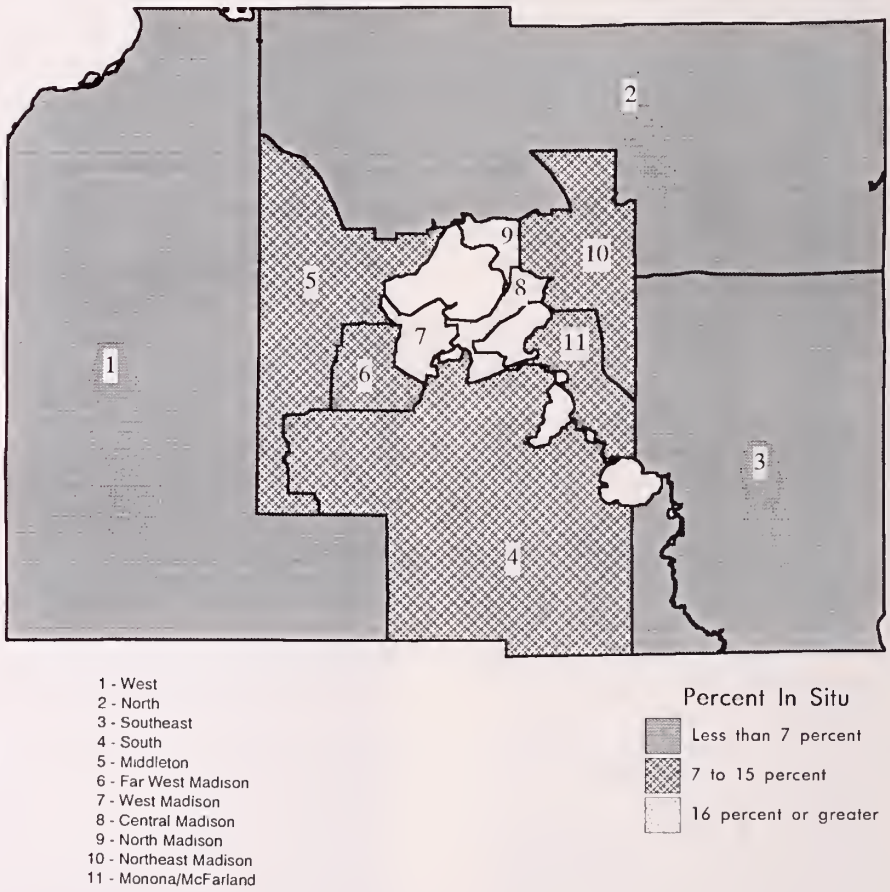

Fig--Percent in situ breast cancer by region, Dane County Wisconsin, 1988-1992.

Monona-McFarland. The proportion of in situ breast cancer in each region was estimated. These proportions were also age standardized, using the 1970 US standard million population, to remove any potential confounding effects of age.

Results

The proportion of in situ cases by region is shown in the Figure and the proportion of in situ disease, is shown in the Table. There is a 3.5-fold difference between the region with the lowest percentage of in situ detection (Southeast Dane County at 5%) and the highest percentage (Central Madison at 17%). The Figure depicts differences in percentages of in situ breast cancer between the urban and rural regions of Dane County, urban being defined as the greater Madison area, Middleton, and Monona, and rural being defined as the rest of Dane county.

Discussion

This study suggests that even within one county, women living in more rural areas are less likely to have their cancer diagnosed in situ--a likely result of less frequent use of mammography. This is consistent with other publications in the literature.

Others have shown that, for women 40 to 75 years of age, higher income, having a regular source of health care, and living in a metropolitan area, were all associated with regular mammography.[5-6] In both 1987 and 1990, women living in metropolitan areas reported more recent mammography screening than their rural counterparts, even after age, race, income, and education were controlled. This is not surprising since facilities tend to be concentrated in high-income urban areas.[6]

Research indicates that mortality due to breast cancer can be reduced by 30% among women aged 50 and older through the implementation of mammography and clinical breast examination screening programs.[7]

A further step in this project will be to design a marketing strategy to target the rural population in Dane County. These data suggest that rural regions in Dane County may be behind their urban counterparts in using mammography screening. A random digit-dialed telephone survey of women age 50 and older in

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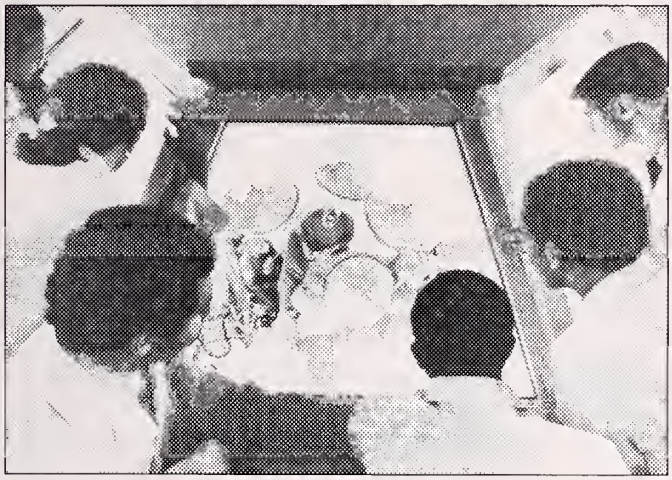

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rural Dane County could help determine reasons for low mammography use. Once reasons for low usage are assessed, public and professional education efforts can be specifically targeted to address those needs. The use of mobile vans and clinic-based, in-reach strategies are important enabling services and are specific examples of services a community could provide.

Our study suggests that, based on percent of cancer diagnosed in situ, women living in rural Dane County may be having less frequent mammography. Using population-based cancer incidence data may permit other health planners to assess the status of breast cancer diagnosis in their communities, and plan programs according to results.

Breast cancer stage at diagnosis, Dane County, Wisconsin, 1988-1992.

Region (#)	N	In situ	Local	Reg/Dist*	Unknown
West Dane County (1)	52	6%	58%	27%	10%
North Dane County (2)	131	6%	54%	32%	8%
Southeast Dane County (3)	73	5%	56%	38%	0%
South Dane County (4)	97	13%	52%	30%	5%
Middleton (5)	43	12%	60%	19%	9%
Far West Madison (6)	122	9%	48%	36%	7%
West Madison (7)	147	16%	47%	27%	10%
Central Madison (8)	134	17%	46%	31%	6%
North Madison (9)	51	16%	59%	25%	0%
Northeast Madison (10)	71	10%	52%	34%	4%
Monona-McFarland (11)	116	12%	57%	26%	5%

See Figure for location in Dane County

* Regional and Distant

Acknowledgements

The authors wish to thank Jerri Linn Phillips for data from the Cancer Reporting System and Robert Adler for assistance with mapping.

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In situ breast cancer correlates with mammography use, Wisconsin: 1980-1992

Darren S. Bush, MA; Patrick L. Remington, MD, MPH; Mat Reeves, BVSc, PhD; and Jerri Linn Phillips, MA, CTR, Madison and Atlanta

ONCE UNCOMMON, the diagnosis of carcinoma in situ of the breast has increased dramatically in the last decade and now accounts for 11% of cancers diagnosed.[1] These tumors are often detected by mammography, and because they have not invaded the basement membrane at diagnosis, predict significantly greater survival rates for the patient. The purpose of this paper is to describe trends in the incidence of carcinoma in situ of the breast over the past decade and compare these trends with trends in mammography.

Methods

Data for all female breast cancer cases diagnosed between 1980 and 1992 (those with ICD-9 codes of 174.0 to 174.9) were obtained from the Cancer Reporting System, Center for Health Statistics, Wisconsin Division of Health. A total of 38,337 cases for the 13-year period were obtained. The data were imported into a SAS database for analysis.[2] Urban or rural status was determined by county of residence, with Metropolitan Statistical Area counties defining urban classification. Cancers with unknown stage were excluded from the analysis.

Data on the trends in mammography were obtained from surveys of mammography providers in Wisconsin, conducted in 1989, 1990, and 1991. The methods of these surveys are described elsewhere.[3]

Results

The incidence rates of in situ breast cancer increased substantially from 1980 to 1992 (Figure). When compared with all breast cancers, in situ breast cancer diagnoses increased by more than 600%, whereas all invasive breast cancers increased by about 80%.

In 1980-1983, rates of in situ breast cancer increased linearly with increasing age, with the greatest incidence among women 80 years of age and older. By 1990, the highest rates of in situ breast cancer was in women age 65 to 79 years of age. The rate of in situ cancer increased the most among women 50 to 64 years of age (relative increase 8.2) (Table).

In 1980-1983, women of color had higher rates of in situ breast cancer. This difference was also observed in 1988-1992. Compared with nonwhite women, however, white women had a greater increase in the rate of in situ breast cancer (6.5 v 4.0) (Table).

Finally, in 1980-1983, the rates of in situ breast cancer among persons living in urban and rural counties were very similar. By 1988-1992, however, persons living in urban counties had a greater rate of in situ breast cancer.

Since 1980, the number of mammograms provided in the state increased from approximately 31,000

Continued on next page

In situ breast cancer rates by age, race, and urban and rural status. Wisconsin: 1980-1992.

	In situ breast cancer rate 1980-83	1988-92	Relative Increase
Age			
Under 50	6.0	31.2	5.2
50 to 64	17.0	139.9	8.2
65 to 79	20.5	145.5	7.1
80 and over	22.7	91.0	4.0
Race			
White	10.8	70.4	6.5
All other races	24.7	99.7	4.0
Urban-Rural			
Urban	12.0	81.6	6.8
Rural	10.2	53.8	5.3
All	11.4	72.1	6.3

* Ratio of the rate in 1992-1988 to 1980-1983

The public health column is not reviewed by the *WMJ* Editorial Board. Bush is the surveillance coordinator for the Wisconsin Women's Cancer Control Program. Dr Remington is the chief medical officer for Chronic Disease Control, Bureau of Public Health, Wisconsin Division of Health. Dr Reeves is an Epidemic Intelligence Service officer with the Centers for Disease Control and Prevention in Atlanta. Phillips is the Wisconsin cancer registrar, Center for Health Statistics. Reprint requests to Patrick Remington, MD, Wisconsin Division of Health, 1400 E Washington Ave, Madison, WI 53703-3041. Copyright 1994 by the State Medical Society of Wisconsin.

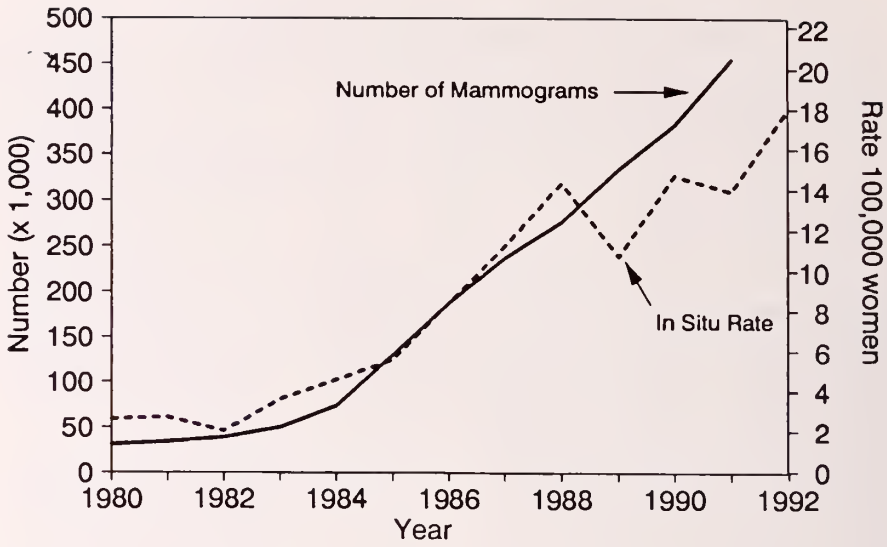
Continued from preceding page
in 1980 to 455,000 in 1991 (Figure). This increase correlates with the increase in the rate of in situ breast cancer (correlation coeficient = .9).

Discussion

The increase in the rate of in situ breast cancer over the past decade correlates very closely with the increase in the number of mammograms provided to Wisconsin women. This is expected, because of the demonstrated ability of a mammogram to detect cancers at an early stage. In community-based trials of the effectiveness of mammography, women in the intervention community have up to five times the rate of in situ breast cancer, compared with women in the control communities.[4]

The increases in in situ breast cancer detection was seen in all groups, which would be expected as mammography use increases over time. Differences in the magnitude of the increase varied substantially among age, race, and urban and rural subgroups. In general, white women in urban areas between the ages of 50 and 64 showed the greatest increase in in situ breast cancer detection, approximately 800%. These are the same groups that have the highest rates of mammography use in the state.[5]

Some limitations of this study have to do with early data from the Cancer Reporting System, where the distinction between localized disease and in situ breast cancer may have been less defined. This limitation was only for the first few years of the Cancer Reporting System, and affected a small number of cases.



Trends in the Number of Mammograms and the Rate of In Situ Breast Cancer, Wisconsin, 1980-1992 (see text for methods).

Wisconsin's statewide Cancer Reporting System is critical in the development and evaluation of breast cancer control programs in the state. A previous study demonstrated the utility of the Cancer Reporting System in evaluating the effect of a statewide screening program.[6] In an accompanying article, we demonstrate the use of the Cancer Reporting System in targeting small geographic areas with the greatest need for breast cancer screening.[7] These efforts will assure that all women in the state benefit from routine breast cancer screening.

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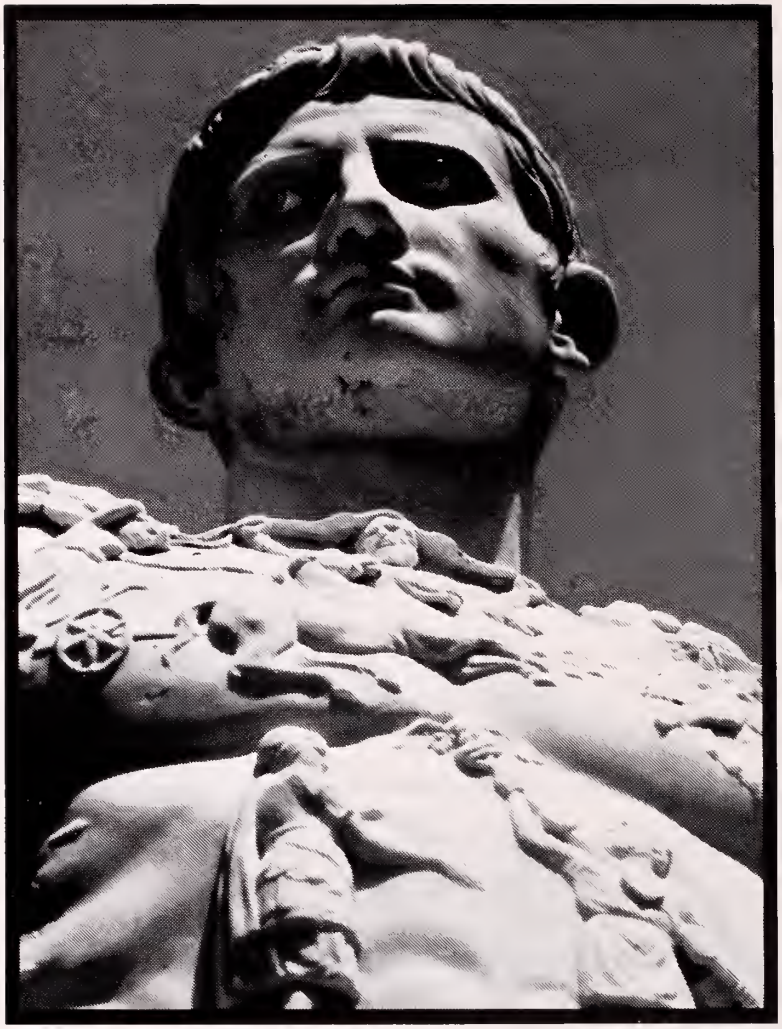

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A glimpse into our past

Richard D. Sautter, MD, medical editor

30 years ago - 1964

Great expectations. The AMA published a monograph series on "the use of computers in medicine, an area of great promise and of particular interest to research scientists, physicians concerned with medical records, and hospital laboratories." How narrow our was our vision for computer applications in the early days!

A distant thunder. The SMS president, Dr W.J. Egan, warned us of the health system reform fits we are now enduring. Writing in the *WMJ*, he asked: "To whose discretion will be ascribed the setting of standards and values, the control of procedures and practices and or resources and means, and management personnel? Who will be responsible and have competency to measure results? Who will be competent in performance appraisal?" Then he warned, "In this field of complex socioeconomics, regardless of all extraneous forces and pressures, I believe it behooves us, as physicians, to get our own house in good order and to continue to improve our housekeeping." Then again, it can be argued that no amount of housekeeping would have avoided the current spasms of reform.

Catchy titles. Wisconsin physicians gave talks around the state on topics such as "Whip lash: fact or fiction," "Sex and Heart Disease," and (my favorite) "Growing Up." Sorry I resurrected them.

Believe it or not. Help wanted ads in the *WMJ* offered psychiatrists a starting salary of $8,519, pediatricians $10,753, and general practitioners $12,000. I know more than one physician who pays that much in liability premiums each year, and some who have that much withheld from their montly income.

60 years ago - 1934

Groping in the dark. A paper on the treatment of tuberculosis in general practice recommended "continued exposure to and inhalation of fresh air" as "indispensable" to the cure of TB. Cold air was considered most beneficial. Exercise was not advised, particularly for patients with a fever. "When the temperature is below 100° F they may take up light reading and gradually extended time for light handicraft work." Read the paper and do a little wood carving, but stay away from the classics?

Safe to say. From a *WMJ* article on rattle snake bites: "the method of filling a patient with whiskey, making a large incision at the point of entrance of the fangs and flooding the incision with strong antiseptic solutions is passé . What is recommended is aspiration of the venom from the site of the bite. This aspiration may be difficult in some areas which brings to mind the statement that the Doctor says your going to die." True as medical advice....

Still true. Dr W.D. Stovall of Madison wrote "That clinical methods of

Continued on next page

SMS president appointed to special legislative committee

Legislative Council Co-chairs Sen Brian Rude and Rep Marlin Schneider have appointed SMS President Richard G. Roberts, MD, JD, to the Legislative Council's Special Committee on School Health Services. The interim study committee will review the current pupil health service provided within the public health system and will develop policy and funding recommendations for improving the school health system. Eight legislators and 11 public members will serve on the committee which will report its findings to the 1995 Legislature. Sen Rude and Rep Peter Bock will serve as committee co-chairs.❖

Continued from preceding page
medical practice are applicable to the prevention of disease has not yet been fully appreciated by the profession." Given that a mere 5% of US health care spending goes to prevention, despite sound evidence that prevention saves both lives and money, it's probably safe to say that the importance of prevention "has not yet been fully appreciated" by a goodmany people--including patients, insurers, would-be reformers, government bureaucrats and, yes, some physicians. "With the genome study certainly much more attention will be paid to the prevention of disease and it will probably be the leading most important specialty in the next decade."

A recurrent theme. "Our press is daily dealing with the high cost of being sick and the public is being more and more educated to the feeling that the expense of medical care should re reduced or given free.... As for state medicine it is not in the offing as is health insurance, it is already here, controlled by private corporation and organizations instead of by the central government." That sounds mighty familiar, mighty contemporary, but it is from a 60-year-old article in the *WMJ*. In a remarkable bit of prophecy, the article concluded with "...the physician of the future will find his star hitched to the tail of the elephant or the donkey or to the soapbox dependent upon the political party in power..." In any case we will be at the wrong end of the animal.

90 years ago - 1904

Would Medicare cover it? The treatment for pneumonia in 1904 was as follows: "Cold compress to heart and lung, hot normal saline enema, hot hip and leg pack, fomentations to the arms, cold mitten friction." The author of the article reported 25 cases, ranging in age from 18 months to 75 years, and identified as such things as "saloonkeeper's wife," "Captain in Mexican army," "French merchant," and "man addicted to the use of intoxicating liquors." According to the report, all 25 patients fully recovered.

Some issues will never be resolved. Even 90 years ago, the issue of abortion engendered heated discussion. At the 1904 SMS annual meeting, Dr T.L. Harrington argued that "the destruction of the fetus at any stage of its existence is homicide" and that "the argument that the life of the mother is of more value than the life of the child is untenable." Dr J.J. McGovern responded that "we are not only justified, but it is our duty under certain conditions to perform an abortion to save the mother's life.... The Medical Society should attempt to stop criminal abortions. When the mother's life is in peril the first consideration must be given the mother." Dr E. Evans said that he believed that 50% of the physicians of Wisconsin would perform criminal abortions. "This statement was indignantly denied by members of the Society." Nothing changes but the names and the faces.

Ye ole AMA. In 1904, the AMA membership stood at 15,000, and the membership of state and county medical societies at 45,000. Annual dues for the AMA were $5, which included a subscription to *JAMA*. Of SMS members, 39% were also members of the AMA. The highest state society membership in the AMA that year was 42%, ranking Wisconsin among the top five.

A good start. In 1903, the SMS suspended publication of its *Transactions* and began publishing the *Wisconsin Medical Journal*. In 1904, the Board of Directors evaluated the *WMJ*'s first year: "After an experience of one year, there are few if any who would wish to return to the old plan. The *Wisconsin Medical Journal* ... has proved itself a clean, able and most valuable medical publication. It contains not only the proceedings of the state and various county societies, but a large amount of other

Registration begins for special SMS PO/PHO seminar

Registrations are now being accepted for a special SMS seminar which will provide physicians with information on practice alternatives in the evolving health care marketplace. The forum is scheduled for Saturday, Nov 5, in Pewaukee.

The morning-only conference will include "nuts and bolts" presentations on working with or building physician-hospital organizations (PHOs) and medical service organizations (MSOs), plus merging physician practices. Representatives from the law firm Quarles and Brady will be on hand to answer questions.

The seminar will also review the formation of single specialty independent practice associations (IPAs) and managed care contracting. The Nov 5 conference will begin at 7:30 AM. at the Country Inn in Pewaukee and will adjourn at noon. Please reserve this date now. Further details will follow in *Medigram*. (Note: the seminar has been scheduled so it will not compete with Packer and Badger football games.) For registration information, call Elaine Stern at 1-800-362-9080 or (608) 257-6781.❖

important matter, and is fully worth the amount of the annual dues of the State Society." Over the past 90 years, the *WMJ* has pressed forward in good times and persevered in hard times, but it has continued to evolve to meet the needs of SMS members. I confess to no small amount of pride in my association with it.

120 years ago - 1864

Regeneration. Dr H. Van Drusen reported a case in which "the operation of removal of the entire one-half of the inferior maxillary bone was followed by reproduction of that bone, in so perfect a manner that very little deformity could be detected. What was most remarkable in the case was that Dr Van Drusen believed he had removed the entire periosteum with the bone. The subject was 5 years old, and the reproductive process was completed within 4 or 5 years after the operation. He believed the new tissue to have been true bone, possessing all its physical properties." Dr Stoddard and Dr Godfrey said they thought it was impossible and that "the new tissue was cartilaginous."

Ovarian tumor. Dr Marks had visited Europe the year before and, in 1874, reported on a surgery he observed in London. A condensed version is offered here: "The anaesthetic was the Bichloride of Methylene. The operation was commenced by making an incision from a little below the umbilicus, in the median line toward the pubis, about five inches in length, through the skin and subcutaneous tissues.... the dissection was continued with light touches of the knife until a small opening was made through the peritoneum, allowing the escape of quite a quantity of fluid, after which the opening in the peritoneum was enlarged ... and the hand passed into the abdominal cavity to search for adhesions.... The tumor, multilocular, was then tapped with a Wells' trocar, but the fluid was too thick to pass freely through the instrument.... The tumor being held up by the assistant, the adhesions between the omentum and tumor were easily broken up with the hand.... (T)he omentum (was) spread out upon a towel, and ... every point where there was the least oozing of blood was ligated ... and the omentum then returned into the abdominal cavity.... The abdominal cavity was afterwards thoroughly sponged out with very soft sponges, first dipped in warm water; numbers of them were crowded into the cavity and allowed to remain while the sutures were being introduced...." It doesn't seem that gynecological surgery has changed very much in the last 120 years. ❖

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County society news

Grant. The Grant County Medical Society approved membership for Louis Fulton, MD; and Duane Salmon, DO.

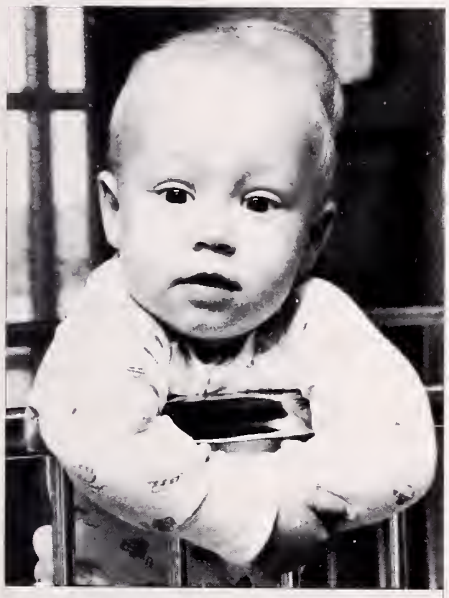
LaCrosse. The following physicians were elected to membership in the La Crosse County Medical Society at the July and August Executive Committee meetings: Jeff S. Cox, MD; Brenda J. Dierschke, MD; Daniel Feddersen, MD; Judy L. Fruehbrodt-Glenzinski, MD; Brian M. Hagan, MD; John G. Jaeger, MD; Elizabeth Kohn, MD; Joseph S. Krien, MD; Jennifer A. Palmer, MD; David Schwartz, MD; Mindy Siegel, MD; James Self, MD; James G. Wilde, MD; and Richard J. Wittchow, MD.

Marathon. The Marathon County Medical Society approved membership for the following physicians at their July 19, 1994, meeting: Sean P. Alwin, MD; James G. Mazalewski, MD; Timothy J. Potter, MD; and Timothy C. Romang, MD.

Milwaukee. The following physicians were elected to membership in the Medical Society of Milwaukee County: Mark Douglas Adams, MD; Bruce W. Cardone, MD; Michael Peter Cinquegrani, MD; Douglas Michael Dewire, MD; Victoria L. Fetter, MD; Randall L. Fiete, MD; Thomas J. Haberkamp, MD; Kathleen M. Hanlon-Lundberg,MD; Kenneth Michael Johnson, MD; Veluvolu K. Rao, MD; Henry Nahum Rosler, MD; Philip Michael Sweetser, MD; Linda Anne Wahby,MD; Douglas M. Wendland, MD; Rosalie L. Blair, MD; Martha W. Bauder, MD; Peter J. Baye, MD; Alicia V. Blando, MD; Bradley A. Bourkland, MD; Rajib Choudhury, MD; Timothy N. Christiansen, MD; Mehran Edalatpour, MD; Milosh Grubor, MD; Safak E.B. Guven, MD; Marjorie Curcio Hawkins, MD; Joseph P. Herzog, MD; Yu-Lan Jankowski, MD; Arthur K. Kennedy, MD; Hyun-Soo Kim, MD; Pero G. Komozec, MD; Gerald P. Loushin, MD; Muhammad Shahid Mustafa, MD; Indrani Nagpaul, MD; Ramon Sumagit Pajarillo, MD; Alexander C. Panagos, MD; Nidal B. Radwan, MD; Daniel H. Rosler, MD; Christopher J. Sabal, MD; Safir U. Shaheen, MD; Ramzi Richard Shehadi, MD; Barry Stephen Siller, MD; Mark James Waples, MD; Barry L. Winton, MD; Anne I. Zeni, DO; and Jessica Y. Zhu, MD.

Richland. Jerel Berres, MD, was elected to membership in the Richland County Medical Society on August 1, 1994.

Wood. The Wood County Medical Society approved membership for the following physicians: Jerome C. Andres, MD; Sikander J. Ansari, MD; Peter J. Dalum, MD; Martin G. Duffey, MD; Caroline A. Fisher, MD; and Catherine G. Henry, MD.❖



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SMS shares Medicaid reimbursement concerns with state officials

In response to an SMS membership mailing, Wisconsin physicians have contacted state Department of Health and Social Services Secretary Gerald Whitburn to voice their concerns about current Medicaid reimbursement and urge Whitburn's support of Medicaid reimbursement increases in the budget he proposes for the 1995-1997 biennium.

In a recent meeting with Thomas L. Adams, CAE, SMS executive vice president, Whitburn disclosed that he had heard from numerous physicians on this issue. Adams subsequently met with Administration Secretary James Klauser to press for reasonable increases in the 1995-1996 budget. Klauser has primary responsibility for finalizing the governor's budget submission to the Legislature.❖

Obituaries

Allin, Robin Nail, MD, died June 27, 1994 in Madison. He was born on February 13, 1911, in Cleburne, Texas. Dr Allin received his medical degree from the University of Wisconsin-Madison in 1934. He completed his internal medicine training at Wisconsin General Hospital in 1939. He served in the U.S. Army Medical Corps for three and one-half years during World War II. He left the service with the rank of Major. He entered private practice in Madison in 1946. Dr Allin joined the Dean Clinic in 1961. Following his retirement in 1975, he became a medical consultant to the Bureau of Social Security Disability Insurance. Dr Allin was a Diplomate to the American Board of Internal Medicine, Emeritus Fellow of the American College of Cardiology, as well as Fellow of the American College of Physicians. He was Clinical Associate Professor of Medicine at the UW Medical School, founding chairman of WISPAC, founding member and past president of the Wisconsin Society of Internal Medicine and the Wisconsin Heart Association. He was Chief of Staff at St. Mary's Hospital, Madison and the Dean Clinic, president of the Dane County Medical Society and a member of the American Medical Association, State Medical Society, and Dane County Medical Society. Dr Allin is survived by his wife, Ruth Emory; two sons, Lyndon K. of Washington, D.C., Robin, Jr., of Hoffman Estates, Illinois; a daughter, Nancy E. Nelson of St. Paul, Minnesota; eight grandchildren; and numerous nieces and nephews.

Bortin, Mortimer M., MD, died July 25, 1994, in Milwaukee. Dr Bortin was one of a team of physicians who performed the first successful bone marrow transplants in 1968. He was a professor of medicine at the Medical College of Wisconsin, and he founded the International Bone Marrow Transplant Registry, based at the medical college. He served as the registry's scientific director for 20 years until 1991. Dr Bortin received his medical degree in 1945 from Marquette University. Survivors include his wife, Barbara; a son, Bruce, of Oakland, California; and a daughter, Meg, of Paris.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

Hoyer, John K., MD, died June 16, 1994, in Marshfield. He was born on July 6, 1924, in Libertyville, Illinois. He received his medical degree from the University of Wisconsin Medical School in 1960, and did his internship at St. Luke's Hospital, Duluth, and a surgical fellowship at the Duluth Clinic. He had a private practice at the Rice Lake Clinic from 1962-1973, and with Doctors O.E. and William Rydell-Gillespie and the Indianhead Medical Group, Ltd., from 1974 - 1991. Dr Hoyer was a member of the Barron-Washburn Medical Society, serving as secretary, treasurer, vice president and president. He was a member of the State Medical Society, American Medical Association and Wisconsin Academy of Family Practice. He was also a member of the Indianhead Chapter of the Wisconsin Academy of Family Practice, where he served as president. He was a member of the Wisconsin Academy of Family Practice Scientific Committee and a charter member of the American College of Emergency Physicians and the American Academy of Family Practice. Dr Hoyer is survived by his wife, Marjorie; two sons, Jonathan and James, both of Minneapolis; one daughter, Dr. Jean Hoyer, Superior; a brother, Warren, Spring Green, and two nephews.

Peckham, Ben M., MD, died June 14, 1994, in Madison. He was born in Milwaukee in 1916. He received his medical degree from Northwestern University Medical School in 1941. He entered the U.S. Navy Medical Corps Reserve in 1943. He began a tour of combat duty in the Pacific in 1944 and was awarded the Purple Heart and Bronze Star Medals, ending his service with the rank of Lt. Commander. Following the war, he received a M.S. and Ph.D. in Physiology from Northwestern University. In 1956, he resigned as Assistant Professor at Northwestern University Medical School to become Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Wisconsin, a position he held until 1983. For the past ten years, Dr Peckham was Emeritus Professor at the UW Medical School. He also served as Associate Dean of the UW Medical School from 1967-1971. He served

as president of the American Gynecological Society, president of the Association of Professors of Gynecology and Obstetrics, president of the Society for Gynecological Investigation, and president of the American Gynecological Club. Dr Peckham was a member of the State Medical Society Fifty Year Club, and the Dane County Medical Society. He is survived by his wife, Ann; three children, Mary Burney of Ann Arbor, Roger Peckham of Cleveland, and Gardner Peckham of Washington, D.C.; and five grandchildren.

Sroka, William Charles, MD, died on June 25, 1994. He was born on December 22, 1921, and received his medical degree from Marquette University in 1946. Dr Sroka served an internship at St. Mary's Hospital in Grand Rapids, Michigan. He practiced medicine in Burlington until his retirement in 1978. Dr Sroka served in the Air Force from 1951 to 1953 with the rank of Captain, spending one year in Korea with the 4th Flight Interceptor Wing. He was a member of the American Medical Association, State Medical Society, Kenosha County Medical Society, and a fellow of the American Academy of General Practice. He served one term as chief of staff at Memorial Hospital. Dr Sroka is survived by his wife, Helen; three daughters, Linda Kadlac of Los Angeles, California, Mary Allen of Stevens Point, and Susan Renner of Redmond, Washington; four grandsons, his mother, Mrs. Chester Sroka, a sister, three nieces and a nephew.❖

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

* Draeger,Margaret R.
* Haesemeyer, Allan J.
* Heggestad, Kay A.
* Mandich, Milka
* Praxel, Theodore A.
* Raduege, William E.
  Springs, Fern E.
* Zondlo, Joseph G.❖

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24 HOURS
- Chance of heart attack decreases

48 HOURS
- Nerve endings start regrowing
- Ability to smell and taste is enhanced

2 WEEKS to 3 MONTHS
- Circulation improves
- Walking becomes easier
- Lung function increases up to 30 percent

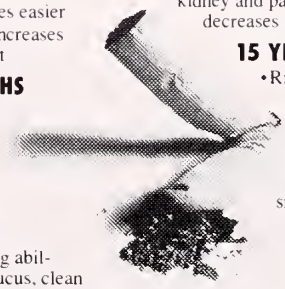
1 to 9 MONTHS
- Coughing, sinus congestion, fatigue, shortness of breath decrease
- Cilia regrow in lungs, increasing ability to handle mucus, clean the lungs, reduce infection
- Body's overall energy increases

1 YEAR
- Excess risk of coronary heart disease is half that of a smoker

5 YEARS
- Lung cancer death rate for average former smoker (one pack a day) decreases by almost half
- Stroke risk is reduced to that of a nonsmoker 5-15 years after quitting
- Risk of cancer of the mouth, throat and esophagus is half that of a smoker's

10 YEARS
- Lung cancer death rate similar to that of nonsmokers
- Precancerous cells are replaced
- Risk of cancer of the mouth, throat, esophagus, bladder, kidney and pancreas decreases

15 YEARS
- Risk of coronary heart disease is that of a nonsmoker



Source: American Cancer Society; Centers for Disease Control and Prevention

Wisconsin Medical Journal instructions to authors

Authorship

Manuscripts are considered with the understanding that they have not been published previously and are not under consideration by another publication.

Each scientific and socioeconomic manuscript must be accompanied by a cover letter containing the following sentence: "In consideration of the *Wisconsin Medical Journal*'s taking action in reviewing and editing this submission, the author(s) hereby transfer(s), assign(s), or otherwise convey(s) all copyright ownership to the *WMJ* in the event that this work is published in the *WMJ*." All co-authors must sign the letter.

The cover letter must also designate one author as correspondent and provide a complete address and telephone number. All coauthors should have contributed to the study and manuscript preparation. They should be thoroughly familiar with the substance of the final manuscript and be able to defend its conclusions.

The *Journal* expects authors to disclose any commercial associations that might pose a conflict of interest in connection with the submitted article. All funding sources supporting the work should be routinely acknowledged on the title pages, as should all institutional or corporate affiliations of the authors.

Editing

All manuscripts will be edited by the *Journal* staff for clarity, organization, grammar, spelling, and punctuation, and in accordance with AMA style (AMA *Manual of Style*, 8th ed, and AMA *Manual for Authors and Editors*). Suggestions for titles are welcome, but are subject to the constraints of clarity, space, grammar and style.

The corresponding author will be asked to review a galley proof prior to publication to verify statements of fact. Galley proofs are for correcting errors; revisions should be made before submission, but must be made prior to final acceptance of the paper. The authors are responsible for all statements made in their work, including any changes made by the editors and authorized by the corresponding author.

Preparation of scientific manuscripts

- Submit papers to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701; Ph: 608-257-6781 or 1-800-362-9080; FAX: 608-283-5401.
- Authors are encouraged, whenever possible, to submit manuscripts on computer disks, using IBM-compatible software. Electronic submissions are also possible. A printed copy must accompany all disk and electronic submissions.
- Typed manuscripts must be submitted in triplicate (one original, two photocopies). Type on one side only of standard-sized white bond paper, using 1-inch margins. Double-space throughout.
- Organization for scientific papers:

Abstracts--150 words or less, stating the problem considered, methods, results and conclusions. Cite no references.

Methods--Describe the selection of observational or experimental subjects, including controls. Identify the methods, procedures and equipment well enough to allow replication.

Results--Provide results in the test, tables or illustrations. If tables or illustrations are used, emphasize or summarize only the most important observations in the text.

Discussion--Discuss the conclusions that follow from the results, as well as their limitations and relations to other studies. Show how the conclusions relate to the purpose of the study. Recommendations, when appropriate, may be included.

References--Limit to 20. Authors are responsible for the accuracy and completeness of references. References must follow AMA style and abbreviations of journal names must follow those in *Index Medicus*. Consult the *Wisconsin Medical Journal* for examples of proper form.

- Acknowledge all illustrations and tables taken from other publications, and submit written permission to reprint from the original publishers.

Style

- Do not use abbreviations in the title or abstract, and limit their use in the text. Acceptable abbreviations of clinical, technical and general terms can be found in the AMA *Manual for Authors and Editors* and AMA *Manual of Style*.
- Avoid the use of medical jargon. Words or phrases that are particular to conversations among medical personnel are inappropriate in scientific writing. (Examples: For "presented with" use "had;" for "experienced a weight loss" use "lost weight.")
- Authors are responsible for supplying the full and correct names of drugs. Use generic names of drugs, unless the specific trade name of a drug is directly relevant to the discussion. If the author so desires, brand names may be inserted in parentheses.
- Units of measure are to be provided in metric, followed by International System units (SI) in parentheses.
- Provide each author's full name and highest academic degree in the byline. If an author holds two doc-

Continuted from preceding page
toral degrees (eg, MD and PhD, or MD and DDS), either or both may be used, according to the author's preference. Honorary American designations (eg FACP or FACS) are omitted. If the author holds a doctorate, master's and bachelor's degrees are omitted. Courtesy titles (eg, Mr, Mrs, Ms) are omitted from bylines and text.

Illustrations
Authors are encouraged to submit black and white photos, graphs and charts when such illustrations will aid in the readers' understanding of the article. If color illustrations, suitable for use on the *WMJ* cover are available, the author should notify the *WMJ* office when the paper is submitted. Use of art submitted as cover illustrations is not guaranteed.

Review process
Each scientific manuscript is reviewed by the medical editor and the members of the editorial board. The opinions of outside consultants may be sought at the medical editor's discretion. The medical editor has the final decision as to whether a scientific paper will be published.

Socioeconomic manuscripts are reviewed by the SMS senior staff and legal counsel. As publisher, the SMS secretary-general manager has the final decision as to whether a socioeconomic paper is published.

Editorials, letters, and soundings are reviewed by the medical editor, SMS senior staff, and legal counsel. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates, and SMS elected officials. Editorials are signed by the authors, are the authors' opinions, and do not necessarily reflect the policies of the SMS. Letters are signed by the authors, are the authors' opinions, and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to editing for length, clarity and style.

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SEND TO: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701. FAX:608-283-5401. Classified ads are not taken over the telephone, but questions may be directed to 608-257-6781 or toll-free 1-800-362-9080.

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NATIONWIDE - Opportunities for the following: IM, FP, OB/GYN, PED, ONC, CD, and more. Send CV to Stan Kent, Stan Kent & Associates, P.O. Box 904, Tremont, IL 61568, or call 800-831-5679, FAX 309-925-5842. 5-12/94

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Medical Meetings-Continuing Medical Education

Specialty Societies

October 7-8, 1994: Wisconsin Psychiatric Association, Holiday Inn, Appleton, WI.

October 7-9, 1994: Wisconsin Society of Otolaryngology-Head & Neck Surgery, Lake Lawn Lodge, Delevan, WI.

October 14-15, 1994: Wisconsin Radiological Society, Concourse Hotel, Madison, WI.

October 15, 1994: Wisconsin Society of Radiation Oncologists, Concourse Hotel, Madison, WI.

AMA

December 4-7, 1994: Interim House of Delegates, Honolulu.

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Naples Realty Services, Inc. 489
Palisades Pharmaceuticals, Inc. 472
Park Nicollet Medical Center 489
Peppino's Restaurant 462
Physicians Insurance Company of Wisconsin ..... BC
SMS Insurance Services, Inc. IFC/469
U.S. Air Force 475
Waukesha Memorial Hospital 493

Miscellaneous

9-12/94

State Medical Society of Wisconsin

Date and location of
1995 ANNUAL MEETING

April 6-9
Grand Geneva Resort & Spa

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free: 1-800-362-9080.

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association.*

Hospital Medical Staff Section
24th Assembly Meeting
December 1-5, 1994
Sheraton Waikiki Hotel
Honolulu, Hawaii

Representation Education and Networking

Send a representative from your hospital medical staff and physician organization to the 1994 Interim American Medical Association Hospital Medical Staff (AMA-HMSS) Assembly Meeting held on December 1-5 in Honolulu. Aside from participating in the development of AMA policy, representatives will have an opportunity to network with colleagues, dialogue with the AMA Board of Trustees, and hear the latest news and information on health system reform.

With a changing health care environment, broader diversity within the physician population, limited resources, and an overriding need for unity of purpose and action by organized medicine, the AMA has undertaken a study of the Federation.

Federation Consortium Study

The study, involving county, state and specialty societies, the AMA, and other related organizations, intends to uncover useful information for developing ways to increase membership, member participation, and advocacy as well as improve communications, medical society performance, and resource utilization.

Project leaders have asked the AMA-HMSS to participate in the process because it effectively represents grassroot physician concerns. Input from each HMSS representative also will be extremely valuable in defining organized medicine in the future.

The 1994 Interim AMA-HMSS Assembly Meeting Education Program will host the Consortium study. Data collected and analyzed will facilitate the following objectives:

- Identify current and future needs, expectations, and preference of physicians and others for organized medicine;
- Explore membership ideas and options;
- Assess how medical societies relate to each other—including ways to be more supportive, avoid duplication of effort, leverage strengths, and better address weaknesses:
- Discover whether there are better tools/technologies that medical societies can use to communicate with one another and their members; and
- Enable medical societies to work smart in a more focused and purposeful way.

Plan to participate in the Federation Consortium on Friday, December 3 from 2:30 to 5:30 pm in Honolulu, Hawaii. Mahalo!

American Medical Association

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\pə(r)-'fȯr-mən(t)s\ : *accomplishment; efficiency; the fulfillment of a promise or request.* (Webster's dictionary)

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Contents

October 1994 Vol. 93 No. 10

Opinions

501 *President's page*
The New Math: Kids + Guns = Dead
by Richard G. Roberts, MD, JD, Madison

504 *EVP report: The view from here*
An ounce of prevention is worth a pound of government
by Thomas L. Adams, CAE, Madison

506 *Editorials*
A clarification of *WMJ* policy
by Richard D. Sautter, MD, medical editor

508 *Soundings*
The tragedy of gun violence
by Wanda Lavendel Bincer, MD, Madison

509 Guns and me
by S. Roger Hirsch, MD, Milwaukee

Scientific

511 Firearm injuries among children and adolescents:
I. The facts
by Murray L. Katcher, MD, PhD, Milwaukee

515 Firearm injuries among children and adolescents:
II. The physician's role in prevention
by Murray L. Katcher, MD, PhD, Milwaukee

521 Trends in motor vehicle and firearm deaths in Wisconsin:
an analysis for examing prevention strategies
by Stephen W. Hargarten, MD, MPH, and Mallory O'Brien, MS, Milwaukee

525 Firearm mortality trends in Wisconsin
by R.D. Nashold, PhD, Madison

Socioeconomic

531 *Public health*
The Wisconsin firearm injury surveillance system
by Patrick Remington, MD, MPH; Nancy E. Chudy, MPH; and Ray Nashold, PhD, Madison

Organizational

535 SMS kicks off statewide CHILD SAFE health initiative to reduce firearm injuries, deaths among children, teens
by Shari Hamilton, assistant editor

537 Rock County physicians seize gun safety initiative
by Cheryl McCollum, SMS field representative

538 Are Wisconsin kids really at risk for gun injuries?

539 CHILD SAFE questions

541 Gun safety checklist

542 New vaccine information forms needed after Oct 1

543 WIPRO encourages ideas for local improvement projects

543 Physician briefs

545 County society news

547 CES Foundation donors

Our cover: "Icarus," by Henri Matisse. Articles related to our cover story theme are indicated by CHILD SAFE

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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President's page
The new math: Kids + Guns = Dead

THIS ISSUE OF THE *Wisconsin Medical Journal* is dedicated to a single idea: Wisconsin's physicians, together with their communities, can heal the terrible wound called gun violence and children. The stark numbers tell only part of the story -- firearms are the second leading cause of death for our young people, killing an average of 80 Wisconsin children each year. The other part of the tragic story is the incalculable pain reflected in the faces of the survivors: a scarred generation of kids who have been injured by gunfire or robbed of the security of a safe childhood; bereaved parents, families and friends who have grieved the stolen promise of their youth.

On the surface, the solution to gun violence seems seductively simple: eliminate guns, or at least eliminate them from the hands of children. On deeper reflection however, the complexities become apparent: the ready availability of 5 million firearms in Wisconsin's homes, the controversies inherent in the Second Amendment's constitutional "right to bear arms," the American culture of violence. For the individual physician, it can feel overwhelming to take on an ailment that may seem more the province of criminologists, psychologists, sociologists or theologists. What can doctors do about this sickness of the soul that afflicts us?

We can begin to think about firearm violence as the public health problem it has become. Rising mortality rates caused us to shift our approach on motor vehicle crashes from that of automobiles as a transportation problem to cars as a public health problem. The result was improved road design, safety belts, air bags and drunk driving laws--and a continued decline in injuries and fatalities.

Richard G. Roberts, MD, JD

Learning a new calculus to deal with gun violence

We must look beyond the conventional wisdom and accurately describe the vital statistics: 68% of firearm deaths are suicides, 28% are homicides (half of which are committed by family members or friends), and 3% are accidents. Most

Continued on next page

victims are male (88%); nearly half are younger than 30. An even better understanding of the dimensions of the problem could be achieved through a firearm injury registry.

We can help to penetrate the sense of denial and inevitability that exists. Much as for the patient with alcoholism, physicians can start the healing by confronting the problem, describing its characteristics and offering hope that something can be done about it. An inquiry about firearms can raise a patient's awareness of a potential problem. Advice on weapon and ammunition security, gun safety, depression recognition, and conflict resolution can improve chances for survival.

We will need to develop therapeutic alliances with our patients and our communities. The job is too big for doctors to tackle alone. The new health care team on gun violence must include law enforcement officials, school teachers and administrators, hunters, parents, clergy, civic groups and young people. We must engage our communities in a dialogue to understand the local manifestations of the gun violence epidemic. Each community's "diagnosis" is likely to be unique-- while common attributes will be found across communities, the conflicts, susceptibilities, resources, and resiliencies will differ.

Public awareness
The CHILD SAFE program was timed for October to coincide with Children's Health Month and the proximity to hunting season, when more weapons are brought out of storage. Over the next month, a number of public service announcements on gun violence and children and CHILD SAFE will be aired on radio stations across Wisconsin. Television stations will also provide air time on the issue and participate in a trigger lock distribution program. Trigger locks can improve the safety of a weapon and can serve as a symbol of the importance of firearm safety.

Community matching grants
County medical societies and their physicians can apply for matching funds to help initiate local projects to address the problem of firearms and children.

Physician and patient brochures
Pamphlets to provide information on firearm injuries and safety have been compiled for physicians. A patient version has also been created.

Resource center
The State Medical Society has been collecting scientific literature and other materials for use by members. A physician or county medical society can call Lynn Sherman (800-362-9080) to inquire about the types of programs to curb gun violence that have been tried elsewhere.

Speakers Bureau
A list of physicians across Wisconsin with expertise on the topic of firearm injuries is available. These experts are willing to speak to physician audiences, schools or civic groups.

Legislative initiatives
The SMS expects to have a bipartisan proposal introduced when the Legislature convenes early in 1995 that would require firearms dealers to distribute a trigger lock with the sale of a weapon.

Applying the new calculus in Wisconsin: CHILD SAFE

CHILD SAFE, Children's Health Initiative with Local Doctors to support Safety and Firearm Education, has been developed by the State Medical Society to address the issue of firearm injuries and children. Approved by the Executive Committee and Board of Directors, CHILD SAFE is the result of the creative ideas of many physicians, SMS commissions and staff. The potential impact of CHILD SAFE has been magnified by an educational grant of $100,000 from the foundation of Blue Cross Blue Shield United of Wisconsin. CHILD SAFE has several elements that address the strategies that arise out of a new calculus

Finding the Solution

CHILD SAFE is the first step in a journey. We should not be discouraged because the journey may seem long or difficult. Polio terrorized families in the fifties and its cure seemed an impossible dream. Medicine helped to show the way then to a healthier childhood. We should not be deterred because we will need new skills to inform and motivate communities. Our tradition, and our salvation, as a profession has been a willingness to walk down a difficult road and create the knowledge and skills needed to reach a better place. That place is a Wisconsin where children are safe because better ways were found to deal with depression or resolve disputes than the immediate finality of a gun blast.❖

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EVP report: The view from here
An ounce of prevention is worth a pound of government

EARLIER THIS MONTH, SMS President Rich Roberts, MD, JD, kicked off the Society's new gun safety program called Child Safe. Reaction to the program has been overwhelmingly positive and has generated several new efforts by physicians at the county level to start similar programs.

A public spirited grant of $100,000 from the foundation of Blue Cross and Blue Shield United of Wisconsin made the magnitude of the program possible.

On a drive back from the Ashland County Medical Society meeting, I reflected on some other social problems that incur health care costs--problems with which we, as individuals, have choices to make. Making the right choices will result in healthier and more productive lives, as well as a reduction in health care spending. Too often, too many of us are making the wrong choices. It's not a definitive list, but here are some of our errors and their estimated costs:

Thomas L. Adams, CAE

Choosing to smoke

The average smoker will soak up $6,239 in excess health expenditures over his or her lifetime. The direct costs of health care delivered because of tobacco-induced morbidity and mortality--that is, physician office visits, medications, hospitalizations, surgery, etc--are estimated to be approaching $35 billion per year. The annual smoking-related health care expenditures by the federal government--that is, by us taxpayers--through Medicare and Medicaid is $4.2 billion.

There is $39.2 billion we spend for health care every year simply because we choose to begin and continue smoking. (If we add the $61 billion estimated indirect cost of smoking through lost productivity, wages and taxes, and of premature death, we find that this lifestyle choice is costing us more than $100 billion annually. All things considered, according to the CDC, the cumulative burden of smoking on the US economy is $500 billion per year.)

Choosing to drink too much

We wink at it, we joke about it, we glamorize it and we deride the "prudes" who warn us about its dangers, but our choice to continue tipping the bottle beyond reasonable limits is costing us 58.2 billion health care dollars every year. That figure includes, among other things: stays in specialty institutions, short-stay hospitals, nursing home care, physician and other professional services, prescription drugs, and support costs. On any given day, somewhere between 25% and 40% of the patients in general hospital beds are being treated for complications of alcoholism.

One of the uglier aspects of this particular lifestyle choice is that it so easily and so often adversely affects the health of people in addition to those abusing their beverages. The CDC estimates that in 1987, alcohol abuse caused 30,000 deaths from unintentional injuries--falls, fires, drownings, etc--and 17,700 from intentional injuries--homicides and suicides. The treatment costs for fetal alcohol syndrome alone reach $1.6 billion annually.

That puts the health care costs of alcohol abuse at $59.8 billion, and the Department of Health and Human Services (DHHS) estimates the total annual economic cost at $85.8 billion.

Choosing to abuse drugs

In 1990, some 20,000 deaths were attributed to the illegal use of drugs. The average US hospital delivers 104 cocaine-addicted babes each year, and the direct and indirect health care cost of drug abuse in America is $10.6 billion. The DHHS puts the total annual economic burden of drug abuse at $58.3 billion. The health care costs of AIDS associated with drug abuse is $1 billion a

year, which brings us to another set of lifestyle choices.

Choosing unsafe sex
Our decisions to have multiple partners and unprotected sex is costing us money, and not just from caring for AIDS patients. The teenage pregnancy rate in the United States is 2.5 times that of Canada and Great Britain, and the unwanted babies, abortions, and many sexually transmitted diseases incur health care (and other) costs. I don't have a dollar figure for it, but various studies estimate that unprotected sexual intercourse led to 30,000 deaths in 1990, including deaths fromcervical cancer, hepatitis B and AIDS.

Choosing to be coach potatoes
I don't have a dollar figure for the health care costs for poor diet and a sedentary lifestyle, but studies have associated them with 22% to 30% of deaths from cardiovascular problems, 20% to 60% of fatal cancers, and 30% of deaths from diabetes.

Choosing to sue
Defensive medicine is costing $15.1 billion. Enough said.

Choosing to act violently
Some $5.3 billion are spent each year to treat health problems created by street and domestic violence.

This edition of the *WMJ* is dedicated to the health problems created by the unsafe storage and use of firearms. In it, you will learn that firearm-related injuries are the second leading cause of death (motor vehicle crash injuries are first) among children ages 10 to 19. You will also learn that more than half the rifles and handguns in the nation are kept unlocked--and more than a quarter of the handguns are kept loaded.

Shooting victims alone, in 1992, cost us $3 billion in medical care, emergency services and claims processing. The average hospital charge for treating a child's gun injury is more than $14,000--and about half of that is paid by Medicaid or absorbed as charity care.

Lost wages add another $34 billion to the gun injury bill, but our decision to settle our differences with violence also costs us billions for criminal investigations, prosecutions, jailing offenders and rehabilitating victims.

❖ ❖ ❖ ❖ ❖

Our lifestyle choices with regard to smoking, drinking, drug abuse, unprotected sex, litigation, and violence costs us $131 billion in health

Continued on next page

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care dollars each year--nearly 15% of total annual health care expenditures. How much more do we spend for--among other choices--choosing not to eat and exercise as we know we should, for choosing not to wear seat belts or helmets, for choosing to pollute our water and air, and for choosing not to learn or take time to relax?

And that is just for the direct health care costs. The total dollar drain on our nation, on our culture, is clearly many times that. And the cost in human terms--in pain, in grief, in fear, in lost love, humor, and creativity--is incalculable. And if we could calculate it, the tally would be too hideous to contemplate.

We Americans can have health system reform, complete with huge cost savings (not to mention healthier, happier lives), right now. No government. No taxes. No regulations. Just choices. Our choices.❖

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board. Write to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.❖

Editorials
A clarification of *WMJ* policy

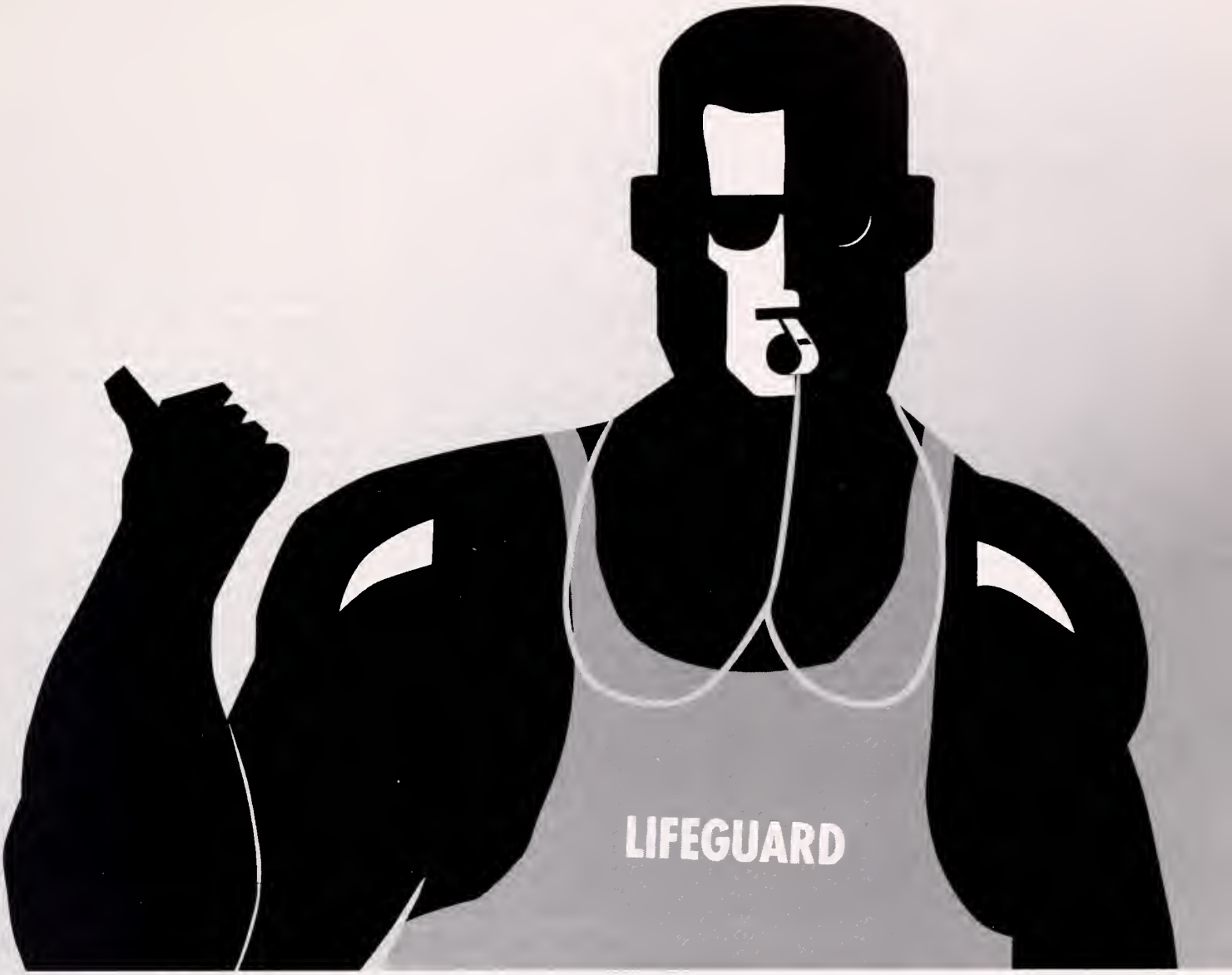
It is important for readers to understand the scope of the *WMJ* Editorial Board's mission. The editorial board, chaired by the medical editor, is responsible for soliciting and screening all scientific, special and soundings articles. Although letters to the editor and editorials are reviewed, and subject to comment, by the medical editor, all signed expressions of opinion belong to the author(s), and neither the *WMJ* nor the SMS take responsibility.

Although feature articles in the socioeconomic and organizational sections are reviewed, and subject to comment, by the medical editor, they are approved for publication by the *WMJ* publisher and editors--and other SMS staff, as needed--and not by the *WMJ* Editorial Board. Modern medicine being what it is, the line between socioeconomics and scientific medicine is sometimes fuzzy. Some of the *WMJ* socioeconomic articles have seemed, to some readers, scientific enough in nature as to warrant review by the Editorial Board. We are in the process of identifying guidelines that will help determine which papers are more appropriate for the scientific section.

In my opinion, any manuscript that makes a specific recommendation for patient care, or reports data regarding a specific disease entity with generalizations and recommendations regarding therapy--in short, any paper that contains methods, results, and comments--should be reviewed by the Editorial Board.

Our intent is to work out a method by which the *WMJ* can provide timely, insightful papers regarding medicine's relationship with social and economic issues while preserving the high standards and editorial integrity of its scientific papers. Comments from *WMJ* readers are, as always, most welcome.

--Richard D. Sautter, MD
Medical Editor❖



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Soundings

The tragedy of gun violence

Wanda Lavendel Bincer, MD, Madison

THE SUPPORT GROUP meets every third Sunday of the month and gives members an opportunity to talk about pain and despair and helps them cope. The anguish that is most frequently discussed is not a symptom of a physical illness but it is nevertheless caused by a frightening epidemic raging through the country, an epidemic of violence. The group consists of family members of victims of homicide. The homicides are most often caused by guns, though some are the result of drunken driving and other kind of violence. The majority of the group members are parents whose sons or daughters have been murdered, some are spouses, siblings or children of parents who have been killed by violent means.

I am a member of this group.

In a society where grief is not a welcome subject and where sadness is poorly tolerated, the group provides a safe and caring place to share experiences and information, as well as to express the pain and anger felt by many. It is here that happy memories of dear ones who were murdered are lovingly shared. This is also the place where the frustration with the criminal justice system is understood and the feeling that our system favors the defendant and that the the victim has no voice, is expressed and validated.

The support group I am describing is the Central Wisconsin Chapter of Parents of Murdered Children and Other Survivors of Homicide Victims. The group meets at Meriter Hospital in Madison, which is being kind enough to provide us with a meeting room.

POMC is a national organization founded by Charlotte and Bob Hullinger after their 19-year-old daughter was murdered. They found themselves alone and isolated with their sorrow until they were able to connect with other couples who shared their grief. Bob Hullinger, a minister, discovered that the clergy did not offer them much support or understanding, nor were health professionals, including psychotherapists, any more informed about bereavement after murder.

The Hullingers' search for people who understood and were willing to hear about their tragic experience started a national network of survivors and an organization, which today has chapters and contact people in almost every state.

Even today, although progress has been made in research on both post traumatic stress syndrome and bereavement associated with it, very few professionals are aware of the needs of victim families or feel comfortable enough to be able to help them.

Most of us do not expect our personal lives to be affected by violence, nor are we prepared when tragedy strikes. It was a Monday afternoon in March 1983 and I was in my office with a patient when I was urgently interrupted by my receptionist and told that my eldest child and only daughter was killed. That was the worst moment of my life: a

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moment I would give anything to erase.

I have had to learn to live with the fact that my lovely daughter was shot execution style in her apartment, having been bound, gagged and blindfolded by her murderers, who have not been caught to this day. I learned about the existence of Parents of Murdered Children soon after Yvonne's death, and came to appreciate the support and compassion of those who came there before me. I also realized that my friends and family were unable to give me the understanding and support I needed at the time and this lead to the birth of the chapter in Madison.

Because gun violence has so changed my life, I welcome the call of SMS President Richard G. Roberts, MD, JD, to physicians to fight the rise of death and injury from gun violence and to raise public awareness of its tragic consequences. Also, I want to take this opportunity to urge my colleagues to be especially sensitive to the bereaved families of victims of crimes and to the fact that most never recover completely after their loss.

In 1992, there were 220 murders in Wisconsin and 23,760 homicides nationally. In 1993, there was a 25.5% increase in homicides committed by juveniles. We read daily of children killing and being killed by gunfire. Statistics tell us how many lives have been taken, but they can not tell us how many other lives have been destroyed or affected by these senseless acts of violence. We are hardly ever told of the resulting and permanent grief and sense of loss families are left with or the frequently resulting illness or even suicide. Nor is there much written or statistics given of the talent and potential of so many who might have become writers, scientists, doctors, artists, and others who could have contributed to our society.

While gun violence is changing lives, many of us are still untouched by this epidemic and unwilling to confront it. Those supporting the right to bear arms speak of the inconvenience of a waiting period and do not seem as equally concerned with the right of every individual to life and safety.

Entertainment bombards us with violence as a solution to most problems without giving equal time to its long-term consequences. Murder as entertainment is very popular in our society. We have dinner games like "How to Host a Murder" or "Murder a la Carte" sold at department stores or bookstores that bear names like "Booked for Murder." Television shows and movies are full of bloody shootings, even cartoons contain violence, but none of them deal with the consequences of the destruction they so irresponsibly portray.

I am deeply concerned with what I see as a lack of compassion and humanity in our lives and a lack of concern and responsibility for ourselves and others. At the same time, we seem to under-value our inner strength and resilience and our ability to survive and overcome the greatest obstacles. Our popular culture, widely disseminated by the media, urges us to be rich and successful, and to win at any price. The price we pay is usually very high.

As a psychiatrist, I see how the lack of a supportive community, the influence of image, and superficial values affect people's lives daily. I believe that, in general, we don't allow enough time to listen to each other or ourselves, and that is at the root of many of our problems, which in turn lead to alienation and too often, to violence.❖

Guns and me

S. Roger Hirsch, MD, Milwaukee

I HAVE PRACTICED MEDICINE for 30 years in a field which is not related to either the medical or surgical treatment of trauma. I am not knowledgeable in the field of firearms or their place within American society. Yet, I have more knowledge of the effect of guns on human life, human behavior, and human death then virtually anyone who might read this paper. I have never owned a gun and have only fired a few military weapons on a target range during basic training in the Army Reserve. How then, can such a poor background in this field result in enough expertise to expound? I will tell you.

Six years ago, my beautiful 26-year-old daughter purchased a .22 caliber pistol from a gun store, placed the barrel in her mouth, and pulled the trigger.

When her life ended, my life went black. From disbelief, to denial, to crushing unending grief, I have wandered since. Between numbing reality and recurrent forays into the maelstrom depths of depression and hostility, I have searched for a reason, a sensible excuse, an answer, not succumbing to guilt but resulting in a luminous solution for prevention. Prevention of other tragedies from firearms, prevention of more stinging pain among the living, is the only good that can come from my daughter's death.

An analysis of her mental state and the conditions of her life would be indicated from a medically scien-

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tific point of view. For physicians, this venue might yield the most fruit. But I am not looking for a medical solution. Physicians are privy only to the minority of situations that lead to firearm violence.

The solution must lie in the recognition by society that handguns serve no useful purpose in our present milieu. Handguns are indicated for the military, the police, and for individuals in unusual occupations where use of fatal force might be necessary for protection. For the vast remainder of citizens other forms of non-lethal personal protection are available.

No jingoistic slogans by political lobbying groups can alter the fact that handguns are manufactured for sale at a profit to individuals who intend to inflict great, if not fatal, harm to other individuals. Otherwise, why use them? Res ipsa loquitor!

No physician, regardless of his or her skill or humanity, can completely reverse the physical damage or mental agony that results from a gunshot wound. We as physicians, however, have more ability--nay, more duty--to communicate to our legislators the need for controls over the sales and distribution of handguns. Currently, the health reform debate centers on cost-containment by diminished fees to hospitals and physicians, as well as by managing (rationing) the distribution of medical services. A significant decrease in the cost of health care can only stem from the alterations of life habits of individuals. Where better to start than restriction of the availability of a common cause of death and what is financially worse, long-term disability? It is insane to pass a bill concerning medical care for and disabilities from gunshot wounds and not oppose the cause of the condition.

When the authors of the Constitution granted us to bear arms, I am sure they could not have had in mind the adolescent shootings and drive-by deaths by gunshot occurring with increased frequency all over the country. Their thought was that a fledgling republic should not be placed at risk by having an unarmed population. We are no longer a fledgling republic, and I don't think our government is a dictatorship against which we must defend ourselves. We have defended ourselves in four terrible conflicts in the last 50 years without requiring arming of the citizenry.

Banning the sale of handguns bears the same relationship to death and injury from gunshots as prophylaxis for AIDS or vaccination for common childhood diseases and other serious illnesses. A handgun ban cannot be left out of general health reform because it is a preventable cause of death and financial stress on the back of every citizen.

It is entirely possible that my daughter could have taken her life in some other fashion if she desired. The finality, however, of using a handgun because of it's great focus of power is clearly greater than if some other method was used. Knives, poisons jumping from heights, mishandling a vehicle, hanging, electrocution are all deadly means of accomplishing the same end, but none has the absolute finality of a bullet. Pressing a trigger seems to require less bravery then using a knife or jumping from a building. Using a gun is too easy and too available.

In the name of humanity, in the name of grief, in the name of medical and financial responsibility, in the name of parenthood, ban the sale of handguns.❖

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Firearm injuries among children and adolescents: I. The facts

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Although injuries, both intentional and unintentional, are the major cause of death of children under age 19, the rate of death from motor vehicle injuries has fallen during recent years, while the rate of injury death from violence is increasing. This increase in death rate is a reflection of greater availability of handguns in our society and greater numbers of handgun-related deaths. This article examines the facts related to firearm death and injury among America's youth. Physicians need to be armed with the facts to lead the forces to remove handguns from the environment of children. *Wis Med J.1994;93(10):511-515.*

CHILDREN AND ADOLESCENTS in the United States are killed with guns at a much higher rate than older Americans and young persons from other countries. National statistics, as well as those in Wisconsin, show a trend toward increasing firearm-related deaths among young people, especially among urban black males. For example, in 1987, 1,300 males younger than 19 were murdered in the United States with guns. During the same year, in Australia, Canada, England, France, Japan, Sweden, Wales, and West Germany *combined*, fewer than 80 males in this age group were murdered with guns.[1,2]

In 1990, in the United States, 19,722 persons age 1 to 34 years died as a result of firearm injury, accounting for 17.6% of all deaths in that age group. Among those 10 to 14 years old, 560 died from a firearm injury (one out of every eight deaths) and among teenagers 15 to 19 years and young adults 20 to 24 years, approximately one of every four deaths were firearm related.[3]

Among teenagers 15 to 19 years, 60% of black male deaths were from firearm injury, compared with 23% of white male deaths. For females 15 to 19 years, 22% of deaths among black females and 10% of deaths among white females were firearm related.[3]

Deaths related to firearms are often categorized as unintentional ("accidental") and intentional or violent (homicides and suicides). This categorization may become unclear when an unintended victim is shot, such as in a drive-by shooting. Among teenagers 15 to 19, 82% of homicides were associated with firearms (91% and 77% among black males and white males respectively); for suicides, corresponding figures were 76% and 69%. The 1990 firearm death rate per 100,000 is shown in the table. The rate rises with age and peaks at 20 to 24 years.

By age 10 to 14, the firearm death rate for black males is more than twice the rate for white males and black females, and 10 times the rate for white females. At ages 15 to 19, firearm death rates were highest for black males (119.9 per 100,000).[3]

Death rates for firearm injuries by age group: United States, 1990.

Age (years)	Deaths (per 100,000 population)
1-4	0.6
5-9	0.7
10-14	3.3
15-19	23.5
20-24	28.1
25-34	21.8

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Similar but less pronounced rates occur in Wisconsin.[4]

Race and gender differences vary by manner of firearm-related death. For young children ages 1 to 4 and 5 to 9 years, firearm homicide rates among black children were higher than rates for white children; however, there were no significant racial differences in unintentional firearm mortality. By ages 10 to 14,significant differences in firearm homicide rates by race and gender occur. The firearm homicide rate for black males 10 to 14 age was more than five times the rate for white males (6.9 compared with 1.3), and the rate for black females was approximately eight times the rate for white females (3.1 compared wiht 0.4). At ages 15 to 19, black male homicide was 11 times the rate for white males (105.3 compared with 9.7), and the black female rate was five times that of white females (10.4 compared with 2.0). Unlike homicide, firearm suicide was higher for white males than for black males at ages 15 to 19 (13.5 compared with 8.8).[3]

From 1985 to 1990, the total firearm death rate among teenagers increased 77% to 23.5 deaths per 100,000, the highest level to date. Although all race-gender groups increased, the largest increase was noted for black males (from 46.5 to 119.9). The black teenage male firearm homicide rate nearly tripled to 105.3 per 100,000. At the same time, firearm homicide rate for white males and black females doubled, rising to 9.7 and 10.4 per 100,000, respectively. Although the firearm suicide rate among black teenage males was much smaller than the homicide rate, it increased 63% to 8.8 per 100,000. In comparison, the white teenage male firearm suicide rate increased by 25%.[3]

Among all teenagers 15 to 19, 39% more deaths occurred from firearms than from natural causes. From 1988 to 1990, the firearm death rate increased 48%, while the natural cause death rate declined 12%. Among black teenage males, the firearm death rate was 2.8 times the natural cause death rate in 1988 and 4.7 times in 1990. Firearms are the second leading cause of death (after motor vehicle related fatalities) for children ages 10 to 19. Among black males, firearm injuries were the leading cause of death among children and young adults ages 10 to 34 years. For children 10 to 14 years, 30% more deaths occurred from firearms than from motor vehicle related injuries.[3]

Firearms and youth homicide

If all Americans were killed at the same rate as young black males, 260,000 Americans would die from gun shots each year. For black males 15 to 19 and 20 to 24 years, firearm homicide was the single leading cause of death, with more than three times the number of motor vehicle deaths. Firearm homicide was also the leading cause of death at ages 25 to 34 years, with 12% more deaths than from HIV. Firearm death rates are increasing yearly, with an average of 4% per year increase for white males ages 15 to 19.[3]

With increasing availability of handguns in the environments of children, arguments that in the past were often settled with fists are now settled with guns, thereby increasing the risk of disability or death from injury.

Firearms and youth suicide

Suicide attempts among teenagers often fail, but the presence of a gun nearly guarantees death. On average, one adolescent 10 to 14 years commits suicide with a gun every 6 hours—approximately 1,500 lives lost annually.[3] After car crashes and homicides, suicide is the third leading cause of death among adolescents and young adults in the United States. From 1953 to 1978, suicide rate among young people tripled, almost entirely due to an increase in the firearm-related suicides.[5] One study showed that 91% of suicide attempts with guns were successful in comparison to 23% of suicide attempts with poisons, and 4% of suicide attempts with knives; thus, primary prevention is essential.[6] Those who keep guns in their homes are at much greater risk of having a suicide in their home than those who do not.[7,8]

Firearms and unintentional injury

Only a small percentage of firearm-related deaths among children are unintentional, and most can be prevented. Since many guns are kept loaded within reach of children, children are at higher risk of being killed or injured by a gun if their parents own one. In the United States in 1990, 4,941 children under age 19 died from gun shot wounds; 538 were shot unintentionally.[3] For every one of these unintentional gun deaths, at least five nonfatal injuries occur. Most children unintentionally kill themselves or other children while they are at play with a gun found in their home or in the home of a relative or friend.[9,10]

Estimates indicate there are more than 200 million firearms in US homes, 49 million of which are handguns.[11,12] A Gallup study showed that more than half of all handgun owners keep their guns loaded at least some of the time, and another study showed that 53% of gun owners surveyed did not keep their guns locked up.[13,14]

A loaded gun in the household may bring a family more danger than protection. In fact, in homes where weapons were kept, for every homicide as a result of self protection, 1.3 unintentional deaths, 4.6 criminal homicides, and 37 suicides occurred--an overall ratio of 43 to 1.[15]

If a gun is used in an occurrence of domestic violence, the likelihood of one of the two participants being murdered is 12 times greater than if another type of weapon is used.[15]

In a recent one-week survey of 29 pediatric practices, consisting of

5,233 respondent families, gun ownership was reported in 37%. Of these, 26% were rifles, 17% were handguns, 32% were other powder firearms, and 5% were non-powder firearms such as BB guns; 13% of those with guns had at least one of them unlocked and loaded (unlocked rifles, 52%; handguns, 51%; loaded rifles, 3%; and guns, 27%). Storage of 52% of these is in the bedroom and 19% in the basement.[16]

It is estimated that 30% of all unintentional shootings could be prevented by the presence of trigger locks and loading indicators. Childproof safety devices could prevent every unintentional shooting in which a child under 6 killed themselves or others,[17] but few guns have these devices; no law requires them.

Firearms in schools

Teenagers who carry guns for protection, to intimidate others, or to be like peers, also bring them to school for these same reasons. The violence of our society is spilling over into the classrooms where fear, rather than learning, is generated. A recent national youth risk behavior survey found that one in 20 students carried a firearm, usually a handgun, in the previous 30 days.[18] In Seattle, half of the 11th grade students having handguns said that they got the gun from parents or from a friend.[19] Metal detectors are increasing in response to guns in school, and students caught carrying guns on campus are immediately expelled, thus forcing the student out onto the street where increased danger is created.

Firearms and crime

Most crimes do not result in homicides and most homicides do not occur during the commission of another crime. A readily accessible gun, however, can turn a highly charged violent nonlethal situation into a homicide. Approximately 42% of murders (3 times as many) take place during arguments, compared with 14% during robberies.[20]

It is estimated that half of all American households have guns.[21,22] Although many of these were purchased for hunting or protection, the purpose can often be forgotten if a depressed or enraged family member is present. Half of the people who shoot and kill family members state afterwards that they did not intend to do so when they drew their weapons.[23] Also, even experienced gun owners can have their gun turned against them by an assailant.

Guns are five times more deadly than knives.[24] A person with a gun does not need to be particularly angry, nor is a direct interaction with the victim even necessary for killing; all the person needs to do is pull the trigger.

Gun sales

Minimal federal regulations exist on the sale of firearms. A license is easy to obtain, and firearm availability rate has paralleled the rising firearm homicide and suicide rates.[25] In 1994, more than 255,000 Americans had a federal license to sell guns. In 1991, approximately 92,000 applied to get a new or renewal of a federal firearms license, and only 52 were denied.[26] Although only machine guns, silencers, short-barreled rifles and shotguns, and "destructive devices" (bombs and grenades) are required to be registered with the government, 80% of all gun crimes are committed with ordinary handguns.[27] American-made guns are not subject to the safety standards of the Consumer Product Safety Commission; it has no authority to regulate firearms.

Costs of firearm violence

Taxpayers bear most of the medical costs for shooting victims. In 1990, approximately $2.3 to $2.9 billion of direct costs (hospitals and long-term care, physician and other professional services, rehabilitation, mental health care, medications, emergency transportation, medical equipment, and supplies) and at least $20 billion of indirect costs (morbidity costs [the value of days lost from usual activities due to injury] plus mortality costs [the current monetary value of future output lost due to premature death]) were consumed by the victims of gun violence.[28,29,30] Adding the value of quality of life lost yields total gunshot losses estimated at $112 billion, including $33 billion in costs for victims under age 22. For youth victims, 60% of the costs resulted from assault and homicide, 20% from suicide, and 20% from unintentional woundings.[30]

In a recent study of 44 acute care children's hospitals, average hospital charges for treating a child's gun injury were more than $14,000, and approximately half of the bills were paid by Medicaid or assumed as charity care.[31] A recent Los Angeles Times article traced the costs of a 12-year-old receiving a spinal cord gun shot wound injury at greater than $1 million for criminal investigation, prosecution, medical bills, rehabilitation, and lost wages.[32] These costs were all paid by taxpayers.

Individual trauma centers lose millions of dollars each year treating gunshot wound patients. This type of loss may force trauma centers to close; in Los Angeles County from 1985 to 1989, 10 of 23 trauma centers closed for financial reasons.[33] No federal taxes on guns are designated for medical care of victims of gun violence; rather, revenues are required to go to hunting-related activities.[34]

Summary

More than 5,000 children under age 19 years die annually of firearm injuries in the United States. Many more children's lives are affected by firearm-related deaths and injuries to the more than 33,000 adult relatives, friends, and neighbors in their lives.[35] The cost of firearm violence exceeds $20 billion annually, much

of which is borne by society in general.

The majority of firearm-related injuries and deaths involve handguns. The American Academy of Pediatrics, in a 1992 statement on firearm injuries, concluded that the "surest way to reduce the effects of firearm-related trauma on children is to remove handguns from the environment in which children live and play."[36]

Physicians have an important role to play in decreasing the availability and accessibility of handguns to children and thereby preventing firearm-related injury and death.[37]

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Firearm injuries among children and adolescents: II. The physician's role in prevention

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Firearm-related injury is a major public health problem in the United States. Many children are exposed to handguns in their own homes and in homes where they play and visit. By use of anticipatory guidance and preventive counseling in the office, physicians can educate their patients about the danger to the family (especially to children) of having a gun in the home. If patients keep a gun at home, they should be counseled to empty it and lock it up. Physicians also have the opportunity to be strong public advocates for establishing policies that lead to increased gun safety in the community. *Wis Med J.1994;93(10):515-519.*

In many urban and rural emergency rooms in the United States, firearm injuries and death have become a daily occurrence. In 1988, one of six pediatricians reported treating a child for a gun-related injury.[1] As firearm-related injuries and death have emerged as major public health problems, physicians have sought solutions to prevent these tragedies. A companion article reviews the facts related to firearm injuries among children and adolescents.[2] Estimates indicate there are more than 200 million firearms in the United States, including handguns in one of four households.[3] This article examines how physicians can contribute to violence reduction by addressing the issue of these guns in the environments of children.

Parents often do not realize that they are exposing their children to danger by keeping loaded, accessible firearms in the home. Although it is commonly thought that keeping a gun at home will protect the family members from crime, studies suggest that keeping a gun at home may be a great danger to family members and acquaintances, in terms of homicides, suicides, and unintentional injuries.[4] Guns may also be taken by children from the home into the community, where they pose a danger to others. If a gun is kept at home, it should be emptied and kept locked up; bullets should never be in proximity to the gun.

Parents must also recognize that their children could be shot in another person's home. Approximately 40% of shootings occur in the homes of friends or relatives, according to some news reports.[5] But most parents are unaware of the presence of guns or how they are stored in places where their children play. Young children have limited capability for comprehension of the danger of guns, and are innately curious. Since firearm injuries are usually very serious, medical care is often too late to save victims; therefore, we must focus on primary prevention of gunshot injuries. If a child handles a loaded gun *even once*, it could end a life.

Patient counseling

Since patients often look to physicians for health messages, physicians can provide guidance to parents about firearm-injury prevention strategies, as well as about other injury prevention strategies aimed at drowning, poisoning, and motor vehicle injury. To convey prevention messages effectively, physicians need to be armed with the facts about gun-related suicide, homicide, and unintentional shootings, as well as about guns in the schools.[2] This in-

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Table 1.--Mnemonic for counseling patients about guns[6]

G: Is there a *gun* in your home?
U: Are you around *users* of alcohol or other drugs?
N: Do you feel a *need* to protect yourself?
S: Do any of these *situations* apply to you?
- Have you *seen* or been involved in acts of violence?
- Have you or someone you know experienced *sadness*, depression, or mental illness?
- Do you have *school*-age children or adolescents in your home?

formation may be given in an initial family interview or as part of ongoing anticipatory guidance in the office. Such counseling may increase awareness, result in behavioral change, and save lives. It may be directed at parents and adolescents, especially those of high risk (with depression, aggressive behavior, or suicidal thoughts).

What to say to parents

As part of routine safety counseling, patients should be advised to make their homes gun free. If a clinically depressed person is at home, the risk to that family is increased in the presence of a gun, even if the gun is locked up. Guns are dangerous household products and should be locked up, just as poisons are locked up; bullets should be locked and stored in a separate place. Parents should also explain to children that guns are extremely dangerous and they should never touch a gun in their own home or in anyone else's home.

Preteens and teenagers may be confused by the violence that they see on television and in the movies. Children often do not comprehend the fatal irreversible consequences of gun violence. Parents should help their children realize that media violence is fantasy rather than real.

Parents must realize that they cannot count on even well-behaved children to be safe around loaded accessible guns in the home. Even though parents discuss gun safety with their children, they must always take precautions for safe storage of guns. With easy access to guns, it is no longer just the troubled child who carries a gun; the mainstream teenager may feel peer pressure to handle a gun or take it from the home. Normal teenage behavior includes the challenging of rules, experiencing mood swings, and acting without giving thought to consequences. Preteens and teenagers, especially boys, may see guns as symbols of power and a means to settle fights. Parents should talk to teens about alternative ways to solve problems.

Parents must also be cautious in allowing teenagers to participate in shooting sports. They should consider the child's personality before allowing him or her to handle a firearm, even in a well supervised situation. Angry and aggressive children should not handle firearms under any circumstances.

How to say it

The method of office counseling is of great importance. The physician should attempt to be nonjudgmental and avoid political controversy. The physician is usually not an expert on guns, but may be an expert on children and teens. First, ask about the possibility of a firearm injury; then keep the message clear and simple: "A gun is the most dangerous consumer item in the home. Guns and ammunition should be made inaccessible. If you keep a gun, empty it out and lock it up." Be a good listener and a good advisor, and respond with sensitivity. Be particularly careful when dealing with the family of an aggressive child, one with suicidal thoughts, or depression. Knowing the facts will give you increased comfort with counseling.

In regions where gun ownership is prevalent, the risk is high, and counseling becomes more important--even for families that do not own guns. Since children may be injured in homes other than their own, parents should be encouraged to talk to the parents of children with whom their child plays or visits. The physician can suggest that the parents ask others, "Have you heard about all these kids getting shot in accidents? Despite my warnings, Joey seems fascinated with guns, so I worry what might happen if he comes across one somewhere. Incidently, do you keep a gun in your house?" Parents also should talk to their children about risk of gun injury outside the home--places where they may visit and play. May, et al,[6] have suggested using the mnemonic "GUNS" in their discussion of prevention of gun violence during patient encounters (Table 1). Physicians may find this very helpful in office counseling.

Advocacy and gun policy

In addition to counseling patients in the office, physicians can participate in public health activities focused on community education, environmental modification, and advocacy in the legislative and regulatory arenas. Progress toward the protection of children and adolescents from firearm injuries will be made slowly and incrementally by using a variety of approaches. Some of the most effective intervention strategies are the most politically unpopular at the present time; however, all of them have a primary focus on decreasing the accessibility and availability of handguns and ammunition in the environment of children. As health care providers trying to

maximize the health status of our patients and our community, we have a responsibility to focus on this important public health problem.

In 1980, Baker and others suggested that intervention strategies be considered in light of the "lifespan" of a gun: the manufacture, sale, possession, and use.[7] This model has been developed further by Teret and Wintemute.[8] Using Haddon's ten generic strategies to prevent injury

Table 2.--Possible interventions to prevent firearm injuries among children and adolescents.[10-12]

- Educate children about the serious danger of guns.
- Develop education programs to promote nonviolent resolution of arguments and use of nonlethal means of self defense.
- Enforce existing gun laws regarding manufacture, sale, and possession of handguns; adopt regulation under current legislation.
- Prohibit domestic manufacturing and importing of high-risk firearms and ammunition.
- Hold manufacturers and dealers liable for injury resulting from firearms they produce and sell.
- Redesign bullets to reduce injury severity and ban hollow-point bullets.
- Strengthen requirements for licensed sellers, including liability for injury, tax, and after-market safety devices.
- Establish a significant annual fee for a gun dealer license.
- Require gun dealers to carry liability insurance.
- Regulate marketing and advertising of guns.
- Establish a national waiting period and background check between application to purchase and sale of firearms.
- Increase sales taxes on firearms.
- Improve weapon-tracing capabilities.
- Store weapons and ammunition in locked boxes separate from each other.
- Require new firearms to have a "child proof," engaged safety catch and loading indicator.
- Encourage installation of trigger locks on firearms stored in the home.
- Hold owner liable for child and adolescent use of handguns.
- Encourage nonlethal measures to increase home security (eg, perimeter lights, better locks, and alarm systems) and to reduce perceived need to own weapons for protection.
- Require firearms safety training, demonstration of proficiency, and mandatory licensure (similar to use of automobiles).
- Delay driving privileges for juveniles convicted of handgun possession.
- Encourage police and others to use non-lethal weapons and techniques to control violent people (eg, pepper gas, bullet proof vests).
- Require police to melt down confiscated firearms.
- Provide bullet proof barriers for cab drivers, convenience store clerks, and other high-risk occupations.
- Establish gun-free school zones.
- Use metal detectors to enhance detection of guns.
- Regulate long-gun ownership and use.
- Ban plastic handguns (and other toy-like guns).
- Establish legislation to reduce deadliness of nonpowder firearms (BB guns).
- Regulate gun imports.
- Regulate manufacture, sale, and possession of ammunition.
- Ban possession of handguns where there are children.
- Ban possession of handguns by minors.
- Ban the sale and possession of handguns.
- Ban manufacture and sale of assault weapons.
- Ban unlawful use of guns and give mandatory jail sentences.
- Incarcerate repeat firearm offenders for longer periods.
- Improve emergency medical services, trauma care, and physical rehabilitation services.

rate and severity by breaking the chain of injury causation,[9] Kellermann proposed another means of organizing firearm injury prevention strategies.[10] Christoffel has proposed a variety of intervention options organized from least restrictive towards most restrictive on firearms.[11,12] Table 2 provides a summary of some intervention strategies.

Some of the intervention strategies (bullet proof booths for clerks at all night gas stations in some neighborhoods; waiting period and background check between application to purchase and sale) have already been implemented, and others are currently being debated. Many people feel that becoming armed will deter crime and violence, while others argue that strong gun control laws are needed to decrease firearm injuries and death. The rising rate of drug use and poverty both in the central city and in rural areas, as well as the mass production of handguns and the increased availability of assault weapons, will contribute to a further increase in firearm injury.

Many of the prevention strategies so effective in the control of other pubic health problems may be applicable to the problem of firearm injuries. Prevention strategies must be utilized from many perspectives. The best approach will come from collaboration of experts in the fields of criminal violence, behavioral science, and health. The politics of gun control have dissuaded many from applying their knowledge to this area.

The American Academy of Pediatrics has urged physicians and other health care providers to inform patients and parents about the dangers of having a handgun in the home. Particular focus should be placed on homes with alcohol or drug-related problems, and those with adolescent boys, especially those with a history of family or peer violence, substance abuse, depression, previous suicide attempts, or carrying of weapons. The Academy also supports efforts to reduce romanticization of gun use in the popular media, and also urges that educational gun safety programs focused at children be carefully evaluated, in order to avoid those that might inadvertently encourage or promote access of firearms to children.[13,14]

Banning the sale and possession of handguns is receiving increased popularity. Since new gun sales have been shown to correlate with firearm suicide and homicide rates,[15] banning sale and possession has the potential to reduce firearm deaths and injuries. Because handguns are so easily concealed, however, possession laws are difficult to enforce. Also, because so many handguns are in circulation, the effect may be less than that hoped for. Gun-return and meltdown programs may be important in conjunction with this approach.

Holding the handgun manufacturer liable for injury caused by the handgun may lead to a decrease in the manufacture and availability of guns. This approach has met with success both from individual cases[16] and through legislation.[17]

Summary

As more physicians are becoming aware that injury and violence prevention is a major public health problem, they are viewing firearm-related injury prevention activities as being within their domain. A recent American Academy of Pediatrics membership survey[18] showed that 92% of responders felt that violence prevention should be a priority issue among pediatricians. One-on-one counseling within the office, to encourage the removal or safe storage of guns and ammunition in the home, is one important prevention activity for the physician. The physician may also choose to support one or more of a wide variety of "policy" strategies that may lead to a further reduction of firearms in the environments of children (Table 2).

Acknowledgements

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Trends in motor vehicle and firearm deaths in Wisconsin: an analysis for examining prevention strategies

Stephen W. Hargarten, MD, MPH, and Mallory O'Brien, MS, Milwaukee

Motor vehicle crash (MVC) deaths in Wisconsin have steadily declined since the 1970s. Multiple prevention strategies have been applied resulting in the lowest MVC death rate in 30 years. If current trends continue, firearms will exceed MVCs in Wisconsin by the year 2001. Multiple prevention strategies based on the public health model need to be applied to firearms. *Wis Med J.1994;93(10):521-524.*

MOTOR VEHICLE CRASHES (MVC) have been the No. 1 injury cause of death in the United States and Wisconsin for more than 40 years. From 1960 through 1993, 1,577,709 individuals died from motor vehicle crashes in the United States and many more have been hospitalized with millions of dollars spent in treating these patients.[1] In the United States for 1992, there were more than 39,000 motor vehicle crash deaths, an estimated 1.7 million disabling injuries,[2] and an estimated $50 billion in economic costs.[3]

Since the 1960s, a public health approach directed at the host, agent or vehicle, and environment has successfully begun to reduce motor vehicle crash deaths and injuries (Fig 1). Multiple strategies including seat belts, air bags, center-mounted brake lights along with reductions in alcohol and driving, and the building and maintenance of safer roadways have all significantly contributed to a reduction of motor vehicle crash deaths in the United States. In the United States, MVC deaths are at a 30-year low.

Many states have experienced significant reductions in MVCs such that MVC deaths are no longer the leading cause of injury death. In seven states (California, Louisiana, Maryland, Nevada, New York, Texas, Virginia and the District of Columbia), firearm injury deaths have surpassed motor vehicle crash deaths as the leading cause of injury deaths.[4] It is estimated that by the year 2004, firearms will exceed MVC as a cause of injury death in the United States.[5]

An emerging injury problem

Examining health trends is an essential element of public health. Timely examination needs to be done to establish priorities and reassess resource allocation. Successful interventions to the public health problem need to be recognized and applied to emerging problems.

This paper describes motor vehicle and firearm injury death trends in Wisconsin from 1960 to 1993. It also outlines strategies for preventing and reducing firearm deaths and injuries, using the public health motor vehicle crash paradigm.

Methods

Data was extracted from three sources: 1) the Wisconsin Department of Health and Social Services, Division of Health, Center for Health Statistics, 2) the Milwaukee County medical examiner's records, and 3) the Wisconsin Department of Transportation's traffic accident database.

The DHSS data reviewed was obtained from computer files of statistical information from death certificates for Wisconsin residents. All deaths attributed to injury are classified according to International Classification of Diseases, Injuries, and Cause of Death (ICD) "external codes." The review included the following ICD codes: E-800 to E-825 for motor vehicle crash deaths, E-965 for homicides, E-955 for suicides, E-922 for unintentional firearm injury deaths, and E-985 for undetermined firearm injury deaths.

The Milwaukee County medical examiner's records were reviewed for selected years for all motor vehicle crash and firearm injury deaths. In cases of suicide, homicide or any death due to injury occurring under suspicious circumstances, Wisconsin law requires the involvement of a corner or medical examiner.

Age- and sex-specific data from the Department of Transportation was reviewed for selected years for all motor vehicle crash deaths. This data base is compiled from motor vehicle accident reports submitted by state and local law enforcement agencies.

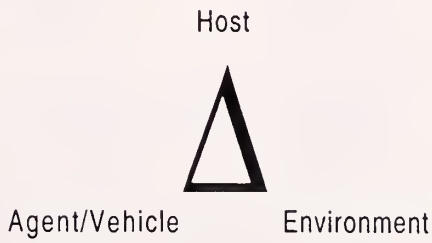

Fig 1 - Epidemiologic model

Dr Hargarten and Ms O'Brien are with the Medical College of Wisconsin's Department of Emergency Medicine in Milwaukee. Reprint requests to: Stephen W. Hargarten, MD, MPH, Medical College of Wisconsin, Department of Emergency Medicine, 8700 W Wisconsin Ave, Milwaukee, WI 53226. Copyright 1994 by the State Medical Society of Wisconsin.

Results

Since 1960 and up to 1993, there have been 31,811 motor vehicle crash deaths in Wisconsin compared to 12,576 firearm injury deaths. Since 1960, motor vehicle crash deaths have initially risen then have consistently decreased since the mid- to late-1960s (Fig 2). In 1993, a total of 703 motor vehicle crash deaths were recorded, one of the lowest figures since 1960 and a decline of 28%. During this same period, firearm injury deaths have steadily increased from 254 in 1960 to 487 in 1993, a 92% increase.

MVC deaths primarily affect young white males aged 15 to 24 (Table 1). MVC death rates have steadily declined since 1980 for this age group while firearm death rates have increased. Between 1980 and 1993, firearm death rates for 15- to 24-year-old individuals increased by 43% compared to a 42% decrease for MVC.

Firearm deaths in the 15 to 24 age group primarily affect black males in Milwaukee County and white males outside of Milwaukee County.

Death rates from MVCs in Wisconsin have steadily decreased since 1960, achieving one their lowest levels in 1993, second only to 1992, in more 30 years (Fig 3). Using projections of the steadily increasing firearms death rate indicates that firearms will be the No. 1 injury death in Wisconsin by the year 2001.

In Milwaukee County, firearms have been the No. 1 injury death since the mid-1980s (Fig 4). Beginning in 1960, an initial upward trend and then a downward trend of motor vehicle crash deaths can be noted with 71 motor vehicle injury deaths occurring in Milwaukee County in 1990. This placed MVC deaths as the No. 3 cause of injury death in Milwaukee County, preceded by falls and firearm injuries. Firearm deaths in Milwaukee County account for 34% of Wisconsin firearm deaths.

Discussion

Much of the success for reducing MVC deaths can be traced to the late 1950s and early 1960s when a paradigm shift occurred. The public health epidemiological model (Fig 1) was applied to motor vehicle crashes and multiple prevention strategies emerged which addressed not only the motor vehicle driver, the occupant, and "safe" driving, but also motor vehicle safety design and the environment. This resulted in increased attention to motor vehicle safety standards and safer roadways with continued emphasis on driver safety. Examples of these multiple approaches include energy absorbing steering wheels, seat belts, air bags, center-mounted brake lights, anti-lock brakes, breakaway poles, wider roadways, and energy absorbing barriers (Table 2).

Interestingly, Wisconsin was the first state to require seat belts in all new cars sold in Wisconsin in 1962. Two decades later, in 1982, Wisconsin enacted a child safety belt law. This was followed in 1987 by a seat belt law for all citizens. Combined, all of these prevention strategies have paid dividends in Wisconsin, with MVC deaths at their lowest level since 1954.

These complimentary public health strategies combined with traditional strategies directed at "the nut behind the wheel" such as speed limit restrictions, drunk driving laws, and minimum drinking age requirements, all have contributed to the decline in MVC deaths.

Application to firearms

Assuming continued trends, firearms will exceed MVC deaths in Wisconsin by the year 2001 (Fig 3). This has already occurred in Milwaukee County. Intentional injuries (homicides and suicides caused primarily by firearms) already account for more deaths in Wisconsin than MVCs (818 homicides and suicides v 703 MVC deaths in 1993).

Activities prohibited in the medical literature, advocating for a paradigm shift for reducing firearm injuries and deaths has only been recently suggested.[5-7] Multiple prevention strategies using the public health model need to be developed, applied, and examined for their effectiveness in reducing these preventable deaths and disabilities. A paradigm shift needs to occur taking firearms from a criminal justice issue to a public health issue amendable to prevention strategies similar to other public health problems.

Detailed information about firearm deaths and injuries are needed. Currently, detailed information on MVCs including occupants, auto-

Table 1. - Wisconsin firearm* and MVC deaths (rates)** age group - 15 to 24 year olds: 1960 to 1990

	1960	1970	1980	1990
MVC				
Total	292 (58)	404 (52)	428 (46)	216 (30)
Males	NA	301	328	141
Females	NA	103	100	75
Firearm				
Total	7 (1.4)	70 (9)	117 (13)	150 (21)
Males	NA	58	105	138
Females	NA	12	12	12

* Includes homicides, suicides, unintentional, and undetermined.
** Death rates per 100,000.
NA data not available.

mobiles, and the environment is available through the national Fatal Accident Reporting System. Wisconsin, through the Department of Transportation, has an Office for Highway Safety dedicated to obtaining critically needed information on MVCs. From this crash information, recommendations for new strategies directed at drivers and occupants, vehicles, roadways, and emergency medical services can be developed and evaluated.

No similar effort is currently in place for firearm-related deaths and injuries. The Office of Justice Assistance has limited information on homicides. Firearm suicides, however, outnumber firearm homicides 2:1 in Wisconsin. To date, there is no bureau or section within the Division of Health or any other statewide Wisconsin agency directing efforts toward reducing all firearm deaths and injuries, regardless of intent. Recently, a call for a national firearm injury reporting system has been made.[6]

Reducing firearm deaths

Three public health strategies for reducing firearm deaths seem apparent.

- Recognition by health policy decision makers that firearm deaths and injuries are a major public health problem warranting sufficient resource allocation.

  In a recent study,[9] it was noted that during the period of 1989 to 1992, there were three measles deaths in Milwaukee County. The resource allocation for dealing with this epidemic was $2 million from the state government. During this same time, in the similar age group affected by measles (0 to 18), there were 104 firearm deaths in Milwaukee County. No comparable resource allocation has been made to address firearm related death in children and adolescents.

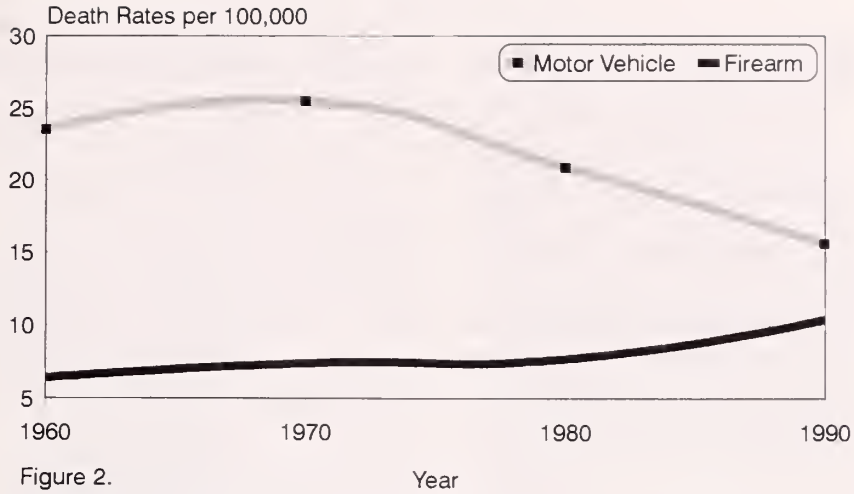

Figure 2.

Fig. 2 - Trends in Wisconsin death rates - motor vehicle crash and firearm injury deaths: 1960-1990

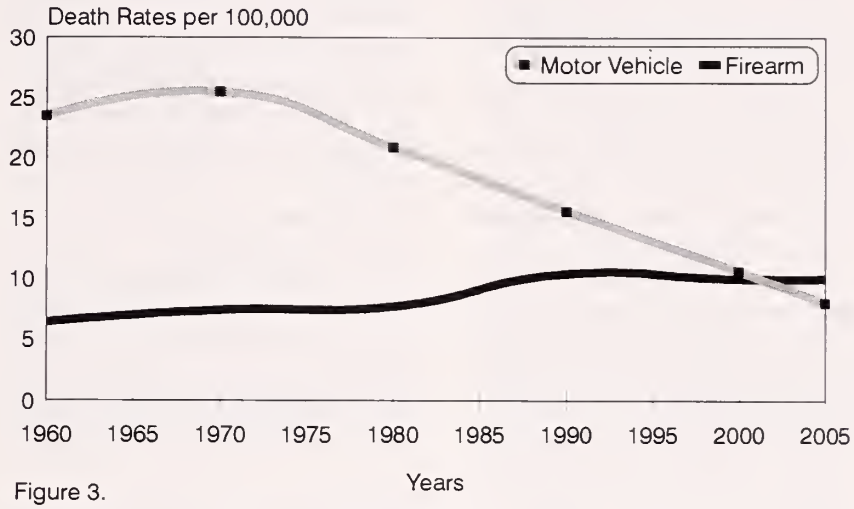

Figure 3.

Fig. 3 - Projected motor vehicle and firearm death rate trends in Wisconsin

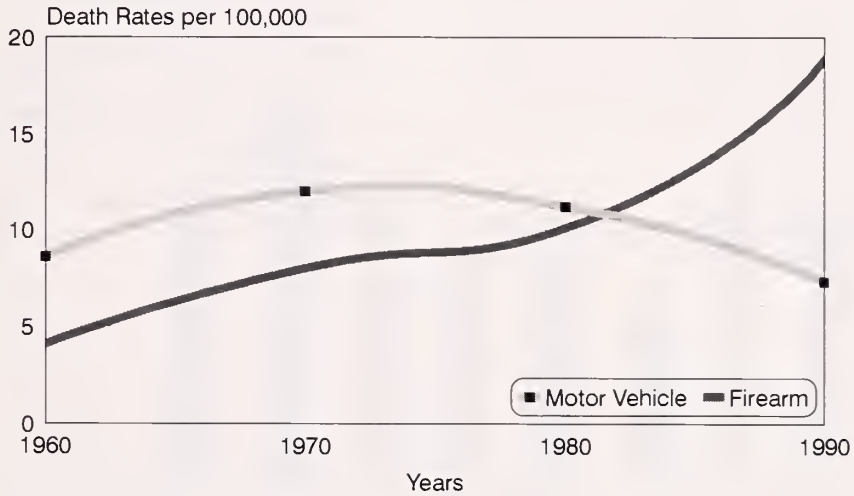

Figure 4. *Includes homicides, suicides, accidental, & undetermined

Fig. 4 - Milwaukee county death rate trends 1960-1990 for firearm and motor vehicle. *Includes homicides, suicides, accidental, and undetermined.*

- Establish a statewide integrated firearm fatality reporting system within the Division of Health.

  Currently, there is a fatality reporting system for AIDS which has been in place from the early 1980s. It is of interest to note that since 1980 there have been 1,286 deaths attributed to AIDS compared to 6,068 firearm deaths.[10] There has been a significant resource allocation for AIDS surveillance but no similar effort has been applied to firearms.

- Establish a legislative agenda in cooperation with physicians, nurses, public health organizations, public policy decision makers, the Wisconsin Department of Justice, and the Wisconsin Division of Health to establish statewide firearm safety standards.

  A US General Accounting Office report published in 1992, suggested that if all handguns had loaded chamber indicators and trigger arresters in place, there would be an estimated 500 unintentional firearm deaths prevented in the United States.[11] To date, strategies to reduce firearm deaths have been limited to homicides and "the nut behind the gun." Broad-based public health strategies which include safety designs of firearms are needed to reduce firearm deaths regardless of intent and causation.

Table 2. - Public health model prevention strategies MVC and firearm

	Host	Agent/vehicle	Environment
MVC	• Vision testing for drivers	• Seat belts • Air bags	• Breakaway poles • Minimum drinking age • Drunk driver legislation
Firearm	• Screening for felons • User specific	• Loaded chamber indicators • Firearm tax identification system	• Community recreation areas

Summary

The public health model of disease has been successfully applied to infectious diseases in the early 1900s and most recently to MVC deaths. A paradigm shift is needed to reduce firearm deaths. The public health epidemiological model needs to be applied to firearms to reduce these tragedies and encourage the development of multiple prevention strategies.

Acknowledgements

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Firearm mortality trends in Wisconsin

R. D. Nashold, PhD, Madison

THE DEPARTMENT OF HEALTH and Social Services (DHSS) has tabulated Wisconsin firearm mortality from death certificates for many years.[1-3] Table 1 shows how firearm mortality in the state has changed over a period of more than six decades.

Under Wisconsin Statute 69.18(2), firearm deaths must be reported to the county medical examiner or coroner where the event occurred. The medical examiner or coroner files the death certificate with the Center for Health Statistics, Department of Health and Social Services.

Fifty-eight Wisconsin counties now have a medical examiner or coroner who is either a physician, registered nurse, emergency medical technician, or other medically trained person. These counties account for about 90% of all firearm deaths. Pathologists perform autopsies for nearly all firearm homicide victims and for most suicides when no note is found.

Literature pertaining to violent death links it to depression, substance abuse, unemployment, education deficits, poverty, racism, firearm accessibility, illegal drug trade, gangs, and a general culture of violence.[4,5] Other earlier social science references link violent death, particularily suicides, to major historical events such as business cycles and wars.[6]

In Wisconsin during 1929, the firearm mortality rate was relatively low at 6.1 per 100,000 population. By 1932, after the economic "crash" and the beginning of the Great Depression, the rate rose to 10.4. With some recovery from the Depression and after repeal of prohibition, the rate again fell to between 6 and 7. The lowest rate recorded (4.8 per 100,000) was in 1943, when a high proportion of young males were in military service and military death data are excluded from state statistics. During the 1950s and 1960s, the rate again ranged between 6 and 7. During the 1970s the rate moved upward, averaging 8.3 for the decade. In the 1980s the rate averaged 8.7; however, in 1990 the rate returned to the 1932 high of 10.4 per 100,000 population, or an average of more than one firearm death for every 10,000 people residing in Wisconsin.

For the last 3 years (1991-1993), the rate has remained at a high level, averaging 9.5 per 100,000 population, or nearly 1 per 10,000 population.

Recent data (1989-1993) show that most firearm deaths in Wisconsin are due to suicide (68%); homicide is next (28%) followed by unintentional injury (3%). In addition, there are a few deaths each year where the intent of the violence remains undetermined.

Firearm mortality rates have been calculated for 10-year age groups based on the most recent 5 years of data (Fig 1). For the four age groups that have both high numbers and rates for firearm mortality, the numbers are illustrated graphically to depict the change that has occurred in the past decade (Figs 2 through 5). These age groups are 10 to 19, 20 to 29, 30 to 39, and 70 to 79.

Suicide accounts for more than half of the deaths in the three younger age groups. The proportion of firearm deaths due to suicide increases with age so that by age group 70 to 79 nearly all of the firearm deaths

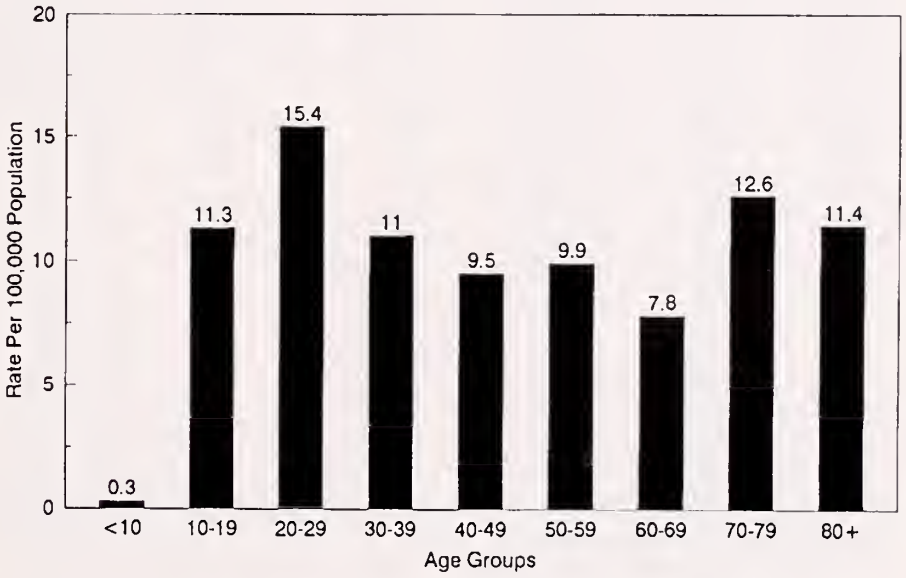

Fig 1 - Firearm mortality rates in Wisconsin by 10 year age groups, 1989-1993.

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Table 1.- Firearm deaths and total death rates* by year, Wisconsin, 1929-1993**

Year	Suicides	Homicides	Unintentional	Total Number	Total Rate
1929	97	31	50	178	6.1
1930	155	54	63	272	9.2
1931	161	68	60	289	9.7
1932	171	64	75	310	10.4
1933	159	32	55	246	8.2
1934	180	47	56	283	9.4
1935	138	15	45	198	6.5
1936	131	24	42	197	6.4
1937	161	23	51	235	7.6
1938	150	39	41	230	7.4
1939	145	25	52	222	7.1
1940	134	23	40	197	6.3
1941	134	26	43	203	6.5
1942	145	29	56	230	7.3
1943	90	11	39	140	4.8
1944	115	14	55	184	5.9
1945	122	22	45	189	6.0
1946	130	16	52	198	6.3
1947	155	22	35	212	6.6
1948	133	9	41	183	5.6
1949	127	21	31	179	5.1
1950	158	18	41	217	6.3
1951	133	17	33	183	5.3
1952	149	29	44	222	6.5
1953	161	19	49	229	6.5
1954	181	16	31	228	6.4
1955	161	27	36	224	6.1
1956	176	17	32	225	6.0
1957	177	26	42	245	6.4
1958	171	20	45	236	6.0
1959	184	28	37	249	6.4
1960	179	30	45	254	6.4
1961	206	43	34	283	7.0
1962	161	25	27	213	5.2
1963	175	37	34	246	6.1
1964	157	30	23	210	5.1
1965	192	34	45	271	6.5
1966	188	52	43	283	6.8
1967	201	63	38	302	7.2
1968	178	64	40	285	6.6
1969	224	71	47	333	7.6
1970	210	65	48	326	7.4
1971	208	84	29	323	7.2
1972	231	86	24	343	7.6
1973	253	97	34	387	8.6
1974	235	99	31	376	8.3
1975	274	111	34	428	9.4
1976	279	90	33	404	8.8
1977	263	85	24	377	8.2
1978	288	73	25	392	8.4
1979	294	90	39	432	9.2
1980	254	78	25	364	7.7
1981	268	90	19	382	8.1
1982	293	98	17	413	8.7
1983	296	80	24	407	8.6
1984	316	65	16	402	8.4
1985	317	96	15	436	9.1
1986	297	80	15	395	8.3
1987	348	83	22	456	9.5
1988	338	89	18	455	9.4
1989	320	106	22	450	9.2
1990	346	144	17	511	10.4
1991	333	139	11	486	9.8
1992	298	144	15	464	9.0
1993	339	133	10	487	9.7

* Deaths per 100,000 population.
Note: Reported firearm deaths from "undetermined" cause are included in the total.

Table 2. - Firearm deaths, male and female, Wisconsin, 1989-93 (annual average)

Total*

	Number	Percent	Rate†
Total	479.8	100.0	9.7
Male	421.8	87.9	17.4
Female	58.0	12.1	2.3

Suicide

	Number	Percent	Rate†
Total	327.2	100.0	6.6
Male	295.6	90.3	12.2
Female	31.6	9.7	1.3

Homicide

	Number	Percent	Rate†
Total	133.4	100.0	2.7
Male	108.8	81.6	4.5
Female	24.6	18.4	1.0

Unintentional

	Number	Percent
Total	13.2	100.0
Male	12.4	93.9
Female	0.8	6.1

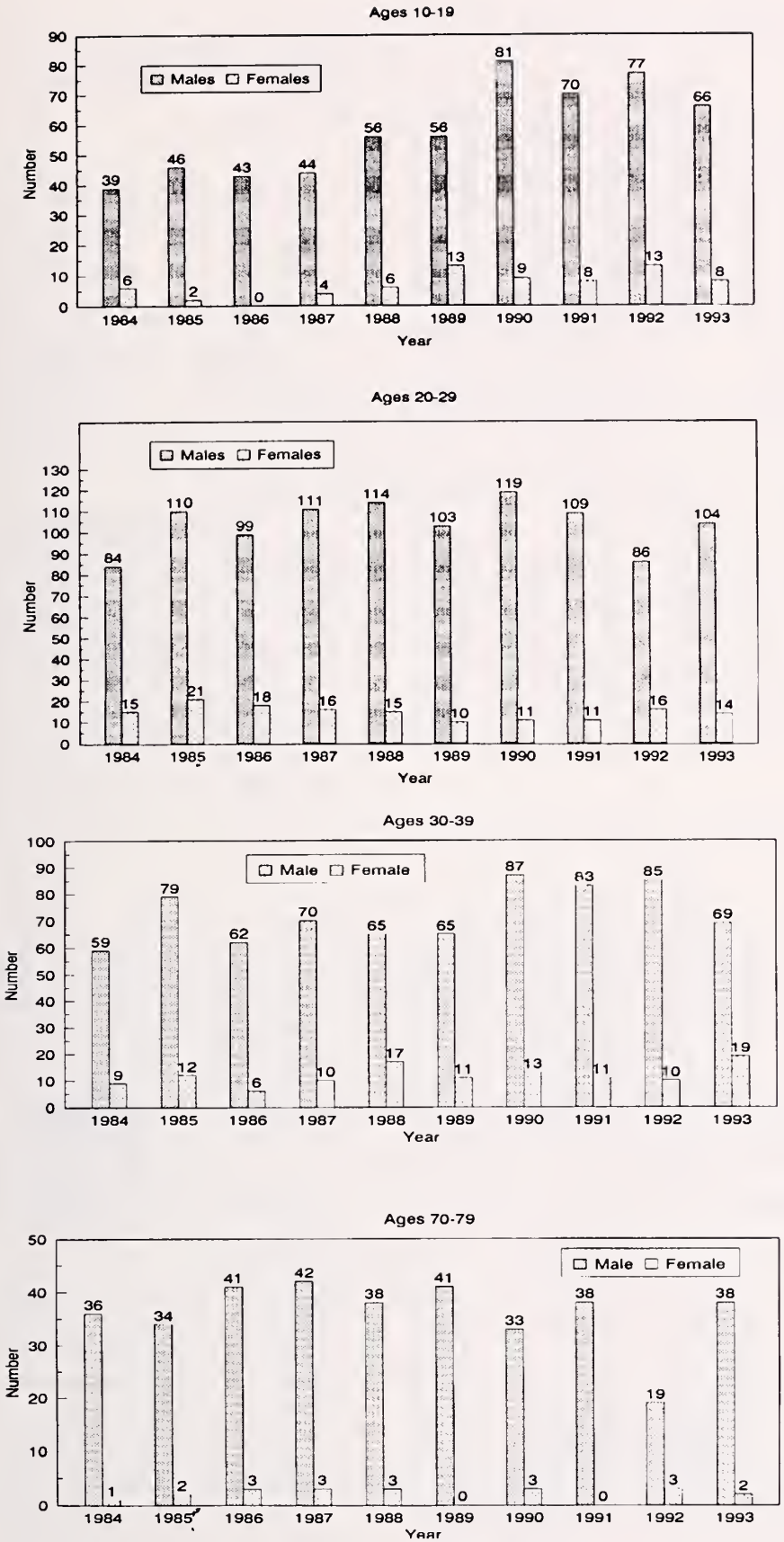
* Includes a few deaths for which intent was undetermined.
† Rate per 100,000 population. Estimated population for 1991: Total, 4,950,100; Male, 2,423,500; Female, 2,526,600.

are suicides.

Firearm deaths are overwhelmingly male (88%). More than 90% of suicides involve a male victim, and nearly 82% of homicide victims are male (Table 2).

Studies show a high correlation between poverty and violence, particularly firearm homicide.[7] Although reliable state estimates of poverty are not available annually, race is highly correlated with poverty and can therefore be used as a proxy variable.[8]

In Wisconsin, the annual number of violent events is high enough to allow the calculation of reliable rates only for whites and blacks. The data



Figs 2-5 - Total firearm deaths for males and females in Wisconsin during 1984-1993.

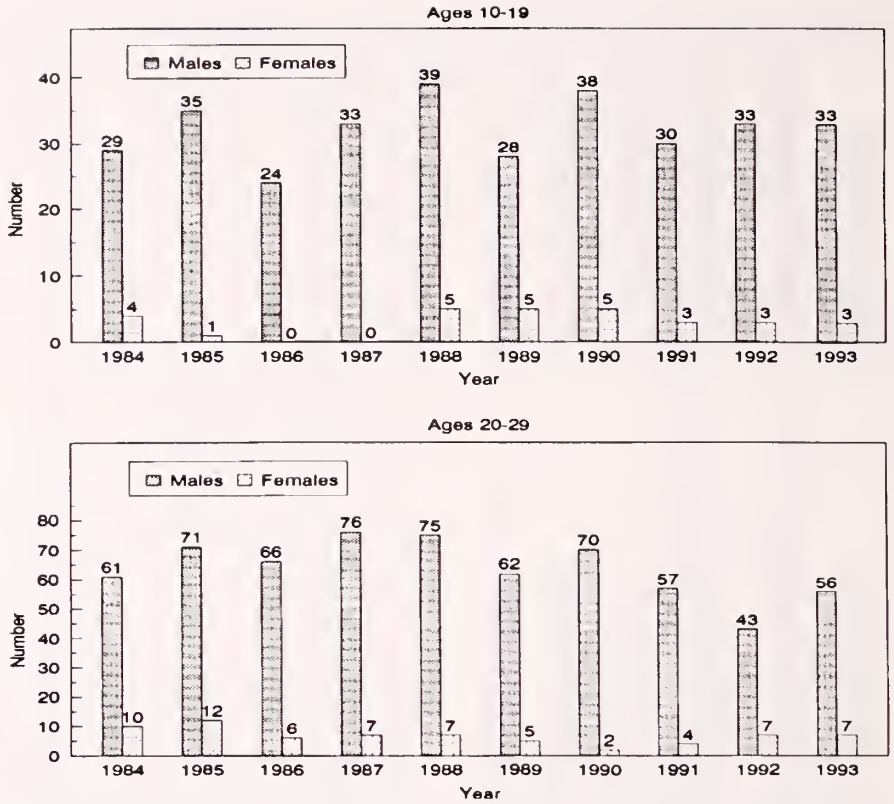
show the suicide rate for whites to be 7 per 100,000 population compared to 3.5 for blacks, and the homicide rate for blacks to be 32.7 compared to 1 for whites (Table 3). Until 1988, most homicides in Wisconsin occurred among the white population; from 1988 to the present, most homicides in Wisconsin occurred among the black population. A dramatic rise in black male homicides for age groups 10 to 19 and 20 to 29 has occurred largely in the past 5 years (Figs 6 and 7). The increase has also occurred largely in the city of Milwaukee, which now accounts for 28% of total firearm deaths and 73% of firearm homicides (Table 4).[9]

The high number of white male suicides for the age groups 10 to 19 and 20 to 24 is shown in Figures 8 and 9. Unlike firearm homicides among youth, however, firearm suicides have remained relatively stable over the 10-year period.

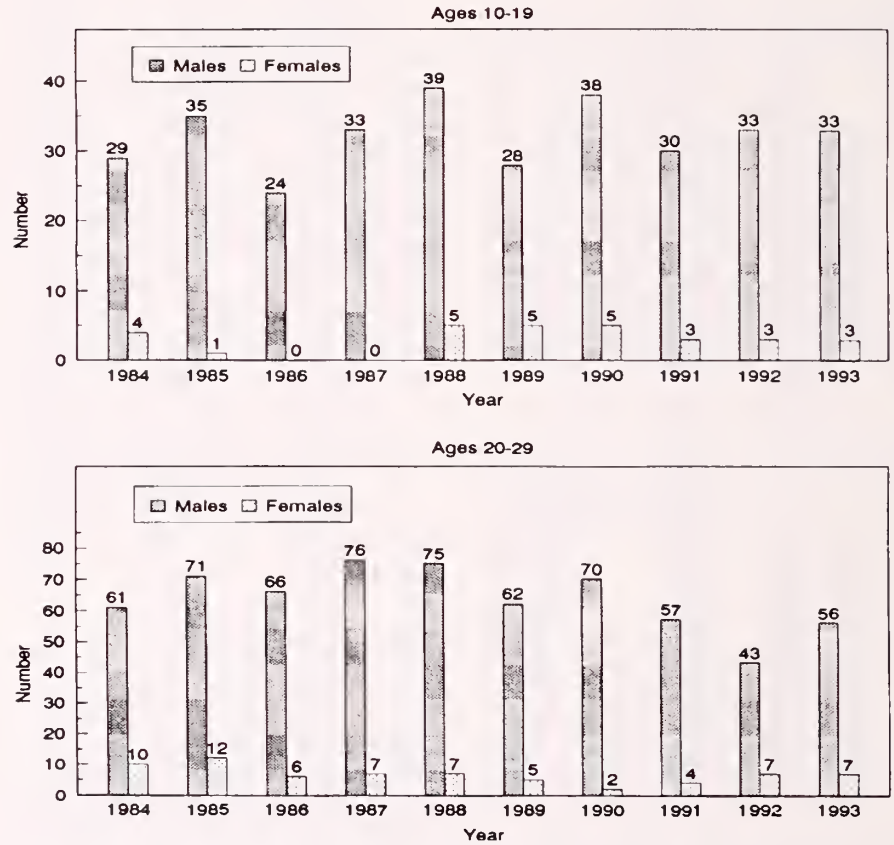
The rise in firearm mortality in Wisconsin between the two most recent five-year periods is attributable primarily to the increase in firearm youth homicides; this increase has occurred disproportionately among young black males below the age of 30. For this group, the average annual number of deaths for the period 1984-1988 was 17; for 1989-1993 it was 51. Although this represents a large increase between the two five-year periods, it should be noted that from 1991 to 1993 the annual number declined from 62 to 50 (Figs 6 and 7). This recent decrease offers hope that well-focused prevention efforts will encourage further decline in firearm homicides in Wisconsin.

Acknowledgements

The author appreciates the contributions of Patricia Nametz, Laura Stephenson-Vine, and other staff of the Center for Health Statistics; and Patrick Remington, MD, chief medical officer for chronic disease in the Bureau of Public Health.



Figs 6-7 - Firearm homicides for black males and females in Wisconsin during 1984-1993.



Figs 8-9 - Firearm suicides for white males and females in Wisconsin, 1984-1993.

Table 3. - Firearm deaths by race Wisconsin, 1989-93 (annual average)

Total*

	Number	Percent	Rate††
Total †	479.8	100.0	9.7
White	380.6	79.3	8.4
Black	92.6	19.3	36.9

Suicide

	Number	Percent	Rate††
Total†	327.2	100.0	6.6
White	315.6	96.5	7.0
Black	8.8	2.3	3.5

Homicide

	Number	Percent	Rate††
Total†	133.4	100.0	2.7
White	46.2	34.6	1.0
Black	82.2	61.6	32.7

* Total includes unintentional and undetermined fatal injuries.

† Total includes other races.

†† Rate per 100,000 population. Estimated population for 1991: Total, 4,950,100; White, 4,519,500; Black, 251,000.

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Table 4. - Firearm deaths in Wisconsin cities over 50,000 population, 1991-93 (annual average number)

City	Total*		Suicides		Homicides	
Milwaukee	135		32.3		100.7	
Madison	13		9.3		2.3	
Green Bay	7		6.3		0.3	
Racine	12		4.3		5.3	
Kenosha	7		5.7		1.3	
Appleton	1.7		1.7		—	
West Allis	6.3		5.7		0.7	
Waukesha	3.0		2.7		—	
Eau Claire	2.7		2.7		—	
Oshkosh	2.7		2.0		0.7	
Janesville	4.7		4.7		—	
La Crosse	4.3		4.3		—	
	Number	Rate†	Number	Rate†	Number	Rate†
Metro Subtotal	199	13.4	82	5.5	111	7.4
Balance of State	280	8.1	241	6.9	28	0.8
Wisconsin Total	479	9.6	323	6.5	139	2.8

* Total includes unintentional and undetermined injury deaths.
† Rate per 100,000 population.

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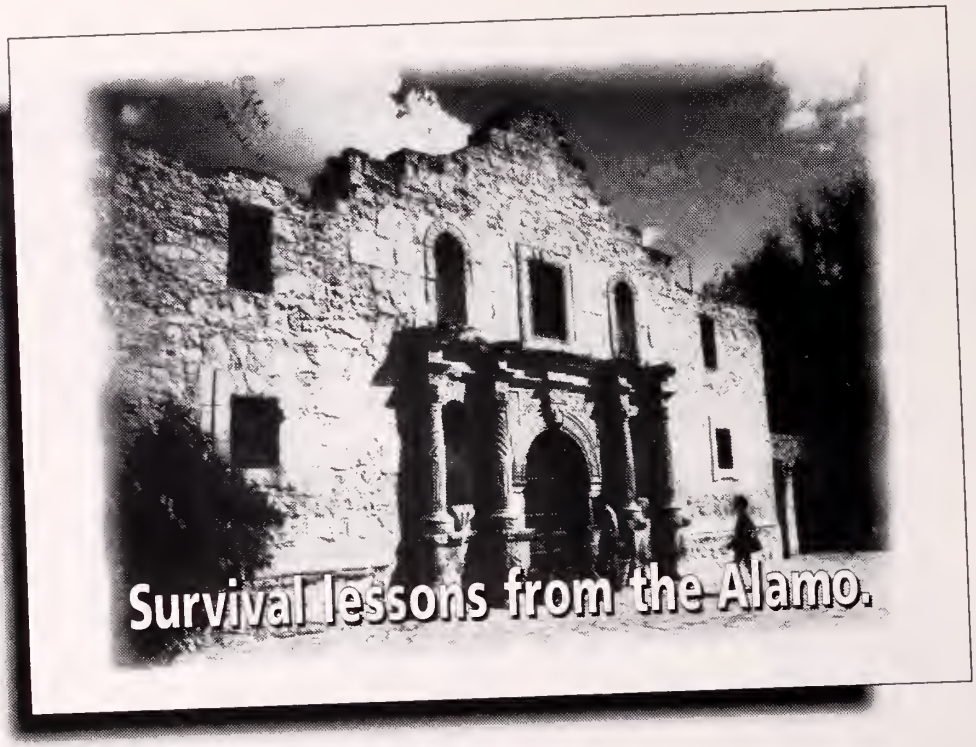

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Public health

The Wisconsin firearm injury surveillance system

Patrick L. Remington, MD, MPH; Nancy E. Chudy, MPH; and Ray Nashold, PhD, Madison

The Wisconsin Division of Health will establish a new statewide injury surveillance program to assess the health and economic costs from firearm injuries. The program, funded through a grant from the federal Centers for Disease Control and Prevention (CDC), will develop, implement and evaluate the multi-faceted surveillance program. Wisconsin is one of six states that will initiate the program.

Background

Firearm-related injuries are a major public health problem in Wisconsin. Each year, nearly 500 persons die from firearm injuries, ranking second only to motor vehicles as a cause of fatal injury. In some communities, such as Milwaukee County, firearms are now the leading cause of injury and death. The health and economic costs from firearm injuries are substantial. Costs for firearm injuries for Wisconsin, estimated from national data, are $1.8 million from firearm deaths and $18.2 million from firearm injuries.[1,2]

Most of the firearm-related injury deaths in Wisconsin are from suicides (69%); followed by homicides (28%) and unintentional injuries (3%) (Fig 1). These deaths, however, may vary by gender and race, as shown in Figure 2.

Nationally, the public health burden from firearm injuries each year in the United States--30,000 deaths and 900,000 non-fatal injuries--has been forcefully presented in scientific journals, social science and law enforcement literature as well as the news media. Despite this increasingly recognized burden, however, relatively few public health resources have been invested in prevention.

Objectives

With the establishment of a firearm injury surveillance system, the Division of Health will have the capability to measure the effects of firearm-related injuries, including the magnitude of the problem, description of those at risk for injury, severity of the injuries, disability, and treatment costs. In addition, with a surveillance system in place, the Division of Health will be able to evaluate the effectiveness of specific interventions on mortality and morbidity.

This program will take the critical first step in prevention, by defining the causes and potential for prevention of firearm injuries. This 3-year program, will have four basic components:

- convene a firearm injury surveillance technical advisory committee;
- establish a comprehensive, state-

Fig 1.--Firearm-related mortality by type in Wisconsin, 1989-1993.

The public health column is not reviewed by the *WMJ* editorial board. Dr Remington is chief medical officer for chronic disease in the Bureau of Public health, Wisconsin Division of Health. Chudy is an epidemiologist in the Section of Chronic Disease Prevention and Health Nashold is director of the Center for Health Statistics, Division of Health. Promotion, Bureau of Public Health. Reprint requests to Patrick L. Remington, MD, Wisconsin Division of Health, 1414 E Washington Ave, Room 96, Madison, WI 53704-3041. Copyright 1994 by the State Medical Society of Wisconsin.

wide firearm injury surveillance system;

- integrate information from the firearm injury surveillance system into public health, clinical, and criminal justice programs; and
- evaluate the utility of the surveillance system in measuring effectiveness of existing or future interventions designed to reduce firearm-related injuries.

Planned activities

During the first year, staff will establish a statewide surveillance system of firearm mortality. This system will build on the experience of local public health agencies in assessing causes of preventable chronic disease deaths in communities.[3] The system will integrate information from vital records, coroners, medical examiners, hospitals, and police to provide a comprehensive assessment of the circumstances surrounding each death.

The surveillance system will integrate information from various sources because death certificate information alone are insufficient to determine the circumstances surrounding the death. Information about the circumstances surrounding these injuries is recorded by police, emergency departments, and coroners. These data, however, are not uniform, and not consolidated in a useable way. Risk factor information regarding violence, the role of alcohol, or relationships between victims and perpetrators will be collected and integrated. In the same way, information about the type of firearm involved and the circumstances of its use (use of lock devices, storage, etc) will be components of the surveillance.

Similarly, little information is currently available on non-fatal firearm injuries, estimated at approximately 2,500 annually in Wisconsin.[4] During the second year, the program will be extended to include non-fatal firearm injuries. Identification of these cases will be facilitated through the use of external cause (E) codes, now required on all hospital discharge records, and through emergency department-based reporting systems. These data will similarly be combined with information from police to provide a comprehensive assessment of the burden from firearm injuries in the state.

With a surveillance system in place, the Division of Health can begin to assess the need for, and the effectiveness of, various prevention strategies. These will be the major activities in the third year.

Partnerships

Wisconsin's application to the CDC included several distinct advantages. First, it will establish the foundation of the system in local public health departments, thus assuring local relevance and action. Second, it will draw from the experience, expertise, and enthusiasm of a number of nationally recognized experts in surveillance, injury epidemiology, and criminal justice. Disseminating information generated from the surveillance system widely throughout the state to public health and law enforcement professionals, policy makers, and the public will be integral to increase the awareness of the public health problem.

The Institute of Medicine's report, *The Future of Public Health*, emphasizes that assessment is a key responsibility of public health, one that cannot be delegated to others.[5] As more surveillance data are incorporated into injury prevention and control programs, greater resources and public attention will be devoted to these important public health problems.[6,7] As C. Everett Koop, MD, stated, "We must realize that vio-

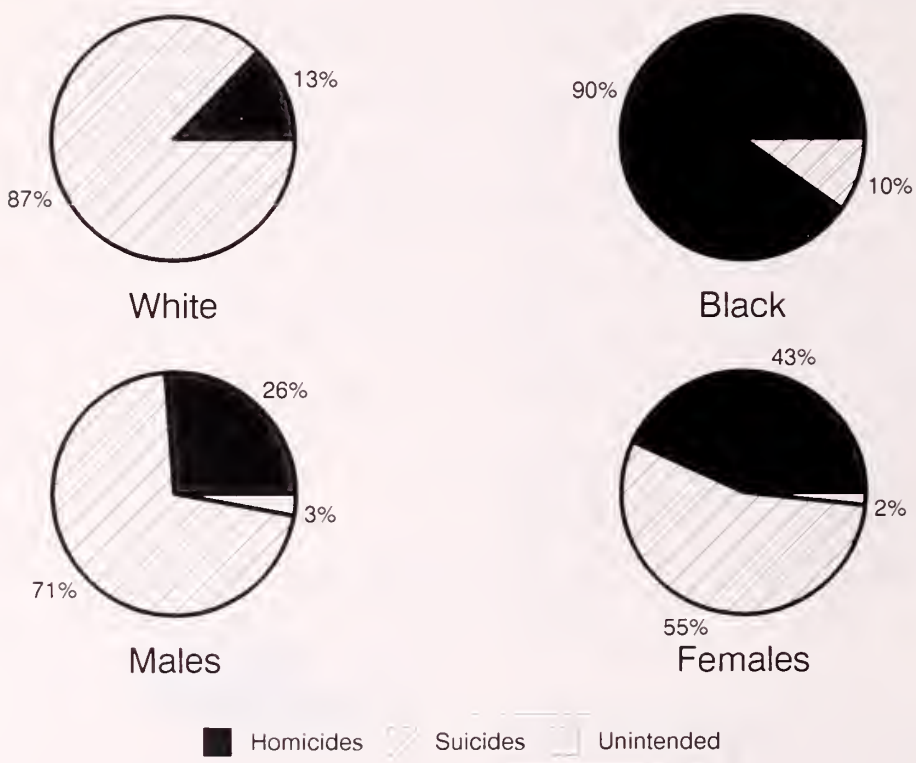

Fig 2.--Firearm-related mortality by race and gender in Wisconsin, 1989-1993.

lence in the forms of abuse, assault, or suicide is not only within the purview of the police and criminal justice system but also of the health system. An informed and aroused public can change the behavior of each of us, but more importantly, it must lead to community outrage and action...."[8]

By establishing a firearm surveillance system, the Division of Health will have information that can be used to develop and target prevention efforts. In addition, the program offers the opportunity for public health to join with law enforcement and social services to collaborate in statewide efforts to reduce unintentional and intentional injuries from firearms.

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- The doctor must be either an MD or a DO.
- Except in unusual circumstances, the service to the community should be uncompensated. (Preference is given to current service over lifetime service.)
- Previous winners of the award are not eligible. *(The Medical Society will notify you if the doctor you nominate is a previous winner.)*
- The deadline for submitting nominations is **Feb. 3, 1995.**

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SMS kicks off statewide CHILD SAFE health initiative to reduce firearm injuries, deaths among children, teens

by Shari Hamilton, Assistant Editor

"...by allowing our movies and television screens to teach our children that the hero is the one who masters the art of shooting and the technique of killing we have created an atmosphere in which violence and hatred have become popular pastimes."
--Martin Luther King, Jr., November 1963

BULLETS AND GUNS should not be more accessible to children than aspirin. That's the message SMS members are sending out to the public as the medical society and its 8,000 physician members launch a statewide program aimed at reducing firearm injuries and deaths among state youth (and associated health care costs) through increased firearm safety and education.

The Children's Health Initiative with Local Doctors to support Safety and Firearm Education or CHILD SAFE is being kicked off in conjunction with October's Child Health Month. The ongoing program will include among other segments: patient education; a public education campaign funded in part with a $100,000 grant from Blue Cross and Blue Shield United of Wisconsin; a free trigger lock distribution pilot program; and a legislative proposal seeking the inclusion of trigger locks in the sale of all weapons sold in Wisconsin.

"As doctors we see firsthand the results of gun-related injuries,"said SMS President Richard G. Roberts, MD, JD, of Madison, in a statewide release. "We see the children who never get the chance to fulfill their potential. We see the devastation the loss of a child has on families and communities. As physicians, we want to help spread the word that these tragedies are avoidable and preventable. Simple firearm safety can help prevent many of these tragedies."

By working to reduce inappropriate youth access to firearms and ammunition, Dr Roberts observed, physicians will be decreasing the likelihood that one of their patients will be among the approximately 80 Wisconsin children who dies each year of gun-related injuries.

In 1993, there were 487 firearm deaths in Wisconsin, according to the Center for Health Statistics. Seventy-six Wisconsin youth were killed. "Most of the gun deaths that occur among young people are shootings or suicides with weapons that were left unlocked," Roberts noted.

For teens, the firearm death rate increased by 43% between 1960 and 1993. In Wisconsin, firearm deaths have now become the second leading cause of deaths for teenagers, ranking after motor vehicle accidents.

Although the common perception is that most youth gun deaths occur as a result of gang violence, Roberts said, the greatest number of deaths actually are suicides by white teenage males. In the last 5 years, teen white male suicide has increased by 31%.

Studies have shown that more than 90% of suicide attempts with guns are successful. In comparison, 23% of suicide attempts with poisons and 4% of suicide attempts with knives succeed. "A gun secured with a trigger lock in a locking gun cabinet may buy the time someone needs to intervene with a 15-year-old who is seeking suicide as a way to resolve personal problems," Roberts said.

In addition to taking an emotional, psychological and physical its toll on state residents, firearm injuries also have a tremendous economic drain on state health care costs. In Wisconsin, $14 million a year is spent on direct hospitalization of patients with gun wounds. Costs of indirect services to injured and lost productivity totals another $190 million.

Blue Cross & Blue Shield United

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of Wisconsin agrees more must be done to prevent youth firearm injuries.

"Gun-related accidents in our state inflict tremendous personal costs on our families and significant economic costs on our health care system. We are pleased to work with the State Medical Society to reduce the incidence of gun-related injuries among our youth," said Thomas R. Hefty, chair and CEO of BC&BSUW.

BC&BSUW is supporting the SMS CHILD SAFE initiative with a $50,000 educational grant from the company's foundation. Much of this money, approximately $25,000, will be used to increase public awareness of the need for gun injury prevention. Working through the Wisconsin Broadcasters Association, the SMS was able to purchase air time across the state during peak airing periods at about one quarter of the usual cost. Public service announcements will be aired by WBA member stations featuring Dr Roberts' public health message on gun safety and education.

The remaining $25,000 of the initial BC&BSUW grant will be used to produce and distribute public eduation materials and purchase approximately 2,000 trigger locks to be distributed through a pilot program aimed at reaching low income families in Wisconsin who may not be able to afford to purchase their own trigger locks. To reduce distribution costs and reach the public easily, locks will be distributed by public safety agencies--such as police, sheriff and fire departments, and the Department of Natural Resources--during the pilot program.

BC&BSUW will make up to $50,000 in additional matching funds available to county medical societies that take an active role in the CHILD SAFE program. All of the BC&BSUW funds are being distributed through the medical society's Charitable Educational and Scientific Foundation. A steering committee, made up of Wisconsin physicians and representatives of SMS staff and Blue Cross and Blue Shield of Wisconsin, will establish guidelines for the matching grants and consider proposals from county medial societies. Three county medical societies--Rock CMS, Dane CMS and Trempealeau, Buffalo and Jackson CMS have already submitted matching grant requests.

The medical society is welcoming the Blues' foundation support, believing coalition building will be the long-term key to addressing societal problems with violence. The SMS will be working with physicians across the state to build these all-important bonds with communities. In addition, Rep Frank Urban (R-Brookfield) and Rep Peter Bock (D-Milwaukee) have agreed to study the feasibility of legislation requiring the inclusion of trigger locks in all firearms sold in the state and draft a proposal for consideration by the state Legislature in January. The SMS will be monitoring the development of this legislation closely.

To date, public reaction to the CHILD SAFE campaign has been excellent. News coverage of the public health campaign has appeared in most major media outlets, featuring interviews with SMS President Richard G. Roberts, MD, JD. More than 40 media interviews--print, radio and TV--have appeared on the CHILD SAFE program.

CHILD SAFE has even won the endorsement of the *Milwaukee Journal*. In a recent editorial the *Journal* commented that a strength of the SMS campaign is that "it doesn't take sides in the divisive gun control debate." "The society is not trying to outlaw firearms; it's just trying to make them safer--a goal that gun-control opponenets and supporters alike should endorse." All elements of the SMS plan are "worthwhile steps, which promise to reduce the grim toll of deaths from firearms," the *Milwaukee Journal* editorial said.❖

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AIR FORCE

Rock County physicians seize gun safety initiative

Cheryl McCollum, SMS field representative

They are simple but powerful ideas--make safer guns, protect our children. That is how Rock Count Medical Society President David Murdy, MD, sees the new gun safety program.

"Guns are dangerous items and there are things people can do to make them safer, especially for children," said Dr Murdy, president of the Rock County Medical Society. Rock County is one of state's county medical societies who has taken the lead in developing its own gun safety initiative. Murdy adds that Rock County has the second-highest rate of firearm-related deaths, just behind Milwaukee.

"It's time to divorce gun safety issues from the political ranks and make this a more constructive issue," Murdy said. While the arguments for and against gun control measures continue, Dr. Murdy says it's a tragedy to see the death rate climb.

"While we may not find the root causes or cures for this problem any time soon, we can change the way we see the problem and try new approaches to reduce the carnage." If we focus on gun safety and responsibility, he adds, we can begin to make a difference that can safeguard our homes and families.

Dr Murdy said he was motivated to action while listening to SMS President Richard G. Robert's speech at the 1994 SMS annual meeting. "While sitting there, I realized it was time to act on this simple, yet powerful idea," he said.

To get the program moving in Rock County, Dr Murdy met with local clergyman Jeff Wild and the two formed the Janesville Fathers for a Safer Community. The group consists of 10 to 15 local people from the business, medical, and religious communities. In the next few months, both the Rock County Medical Society and Janesville Fathers for a Safer Community plan to educate the public to make guns safer in their community. The goals of the campaign are:

- increase firearm safety awareness in the community;
- urge gun owners to keep their guns securely locked and ammunition away from children;
- provide firearm safety instruction for all children; and
- increase the understanding that guns are dangerous and must be treated with care and respect.

Plans for the campaign include a free trigger lock distribution program and advertisements on billboards and radio and in newspapers. The group is also working to distribute the Eddie Eagle program to the first, third and fifth grades in the school district. One issue the Eddie Eagle program focuses on is to tell students that if they ever find a gun, to stop and find an adult.

The group has already raised $8,000 for the initiative, $2,000 of which came from the county medical society. They also hope to receive a portion of the matching grants from the Blue Cross & Blue Shield United of Wisconsin.

To demonstrate the need for such a program, Dr Murdy's points out that, in Wisconsin, firearm deaths are the second leading cause of death for youths age 13 to 19, and more than 90% of children killed by guns were boys. Since 1988, the suicide rate has increased by one third and the homicide rate by 500%. Among blacks, homicide is the No. 1 cause of death until age 40.

Rock County has also seen its share of gun deaths. According to

Continued on next page

SMS seminar on physician practice strategies set for Nov 5

Registrations are now being accepted for a special SMS seminar which will provide physicians with information on practice alternatives in the evolving health care marketplace. The forum is scheduled for Saturday, Nov 5, in Pewaukee.

The morning-only conference will include "nuts and bolts" presentations on working with or building physician-hospital organizations (PHOs) and medical service organizations (MSOs), plus merging physician practices. Local physicians and attorneys will present the material.

The seminar will also review the formation of single specialty independent practice associations (IPAs) and managed care contracting. The Nov 5 conference will begin at 8 AM at the Country Inn in Pewaukee and will adjourn at noon. The registration fee for SMS members is $49; for nonmembers, $99. For registration information, call Elaine Stern at 1-800-362-9080 or (608) 257-6781, ext. 386.❖

Continued from preceding page
Murdy, two Beloit children died last year in a handgun accident and a 10-year-old Janesville boy recently shot and killed his father. Guns are also increasingly being found in schools. In Rock County, an average of 14 people are killed by firearms annually. Eleven of these deaths are suicides, the highest rate in the state. "Reducing easy access to guns can prevent some shootings," he said. People can keep guns safe by using individual trigger locks for each gun and locking up unloaded guns and ammunition separately. They can also take firearm safety and training course and make sure their children do the same.

Dr Murdy says the local initiative has received some good press in the local newspaper and that many people are excited about the program. It's a winning proposition for Rock County Medical Society, he said, adding that each community needs a gun safety program.❖

Are Wisconsin kids really at risk for gun injuries?

An average of 80 Wisconsin kids die each year as a result of firearm injuries. For Wisconsin teens in the last 5 years (1989 to 1993) as compared to 1984 to 1988:

- overall firearm death rate has nearly doubled (from 86/100,000 to 166/100,000);
- white male firearm suicide has increased by 31% to 152/100,000;
- gun homicide has increased more than five times to 73/100,000; and
- firearm deaths have become the second leading cause of deaths for Wisconsin teenagers, ranking after motor vehicle accidents.

What's ahead? Upcoming SMS CHILD SAFE activities include:

- the CHILD SAFE steering committee has begun considering proposals from county medical societies and other physician groups for matching grants to be used to reduce firearm injuries among youtha (a proposal from Dane County has already been tentitively approved);
- public service announcements airing on radio between Oct 10 to Nov 3 as part of Wisconsin Broadcasters Association program;
- distribution of patient education brochures and posters;
- preparation of gun safety publicity in advance of deer hunting season;
- coordination of media interviews for the SMS president and other physician spokespersons;
- release of thise special issue of the *Wisconsin Medical Journal* on gun-related injuries and deaths and subsequent press releases.
- launching of a speaker's bureau on firearm safety and violence prevention;
- publicizing the availability of the SMS as a community group resource center on gun-related injury data and prevention;
- support of legislation mandating that trigger locks be included in all commercial gun sales in state;
- distribution of trigger locks to pilot program; and
- help physicians form coalitions within their communities to identify and address public health problems such as firearm injuries.❖

CHILD SAFE questions

What is a trigger lock? Why will the SMS be giving them away?
Trigger locks are devices that fit over the trigger mechanism of a gun, rendering it incapable of firing. Trigger locks vary in price from about $4 for very simple devices to $25 for locks with electronic alarms. MasterLock, a Wisconsin company, sells a popular trigger lock, which the SMS has obtained to be used in its pilot trigger lock distribution program funded by the Blue Cross Blue Shield United Foundation.

When will trigger locks be available?
SMS is already distributing 2,000 free trigger locks across the state through public safety agenices--police and fire--as part of pilot program. More trigger locks will be available in subsequent months due to applications for matching grants from Blue Cross & Blue Shield from county medical societies.

There are an estimated 5 million firearms in Wisconsin, so SMS will not be able to provide locks for all. The free tirgger lock distribution program is aimed at those who might not be able to easily afford to purchase their own locks. Trigger locks are available (between $4 and $25 for locks with electronic alarms) at sporting goods stores, hardware stores, and farm supply stores.

Why are trigger locks helpful?
The locks decrease the chance that a child or adolescent will fire a weapon by accident injuring themselves or someone else.

If a child or teen wants to commit suicide, the locks will slow them down. They will have to access the key which may give them time to rethink their action or allow someone else time to intervene.

More than 200,000 guns are stolen each year, thieves have a difficult time removing the locks, experts say, and often when the lock is removed improperly the trigger mechanism is damaged so the gun won't fire.

How do I incorporate gun safety discussions into my practice?
In upcoming weeks, the SMS will supply you with patient education materials detailing steps parents can take to help protect their children--teach firearm safety; secure all guns; store ammunition separately; and discuss nonviolent means of conflict resolution.

When you are talking with your patients about their health, ask if there are guns at home and if they are secured in the event of theft. If there are children at home or children who are frequent visitors (grandkids, neighbors, etc), remind your patients of the need for increased safety. Ask parents if guns are accessible in the homes where their children play.

The SMS encourages you to consider organizing a local group. As physicians you have a unique role as leaders in your community. The SMS wants to support you as you reach out to your community, and SMS staff is developing resources to help you increase public awareness on this issue.

Talk to your field staff representative or call the SMS Physician Outreach at 1-800-362-9080 or (608) 257-6781.❖

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Through CHILD SAFE, Wisconsin physicians are working to reduce gun-related death and injuries among youth. Won't you join us?

To keep your CHILD SAFE:

* Educate your children about firearms. Make sure they know what to do if they encounter an unattended weapon. (Stop! Don't touch. Leave the area. Tell an adult.);

* Remove unneeded guns from your home;

* Unload and lock all guns out of sight. Secure your weapons with low-cost, key-operated trigger locks. Store ammunition separately; and

* Talk to your doctor about making your home a safer place.

Keep Wisconsin kids bullet-free and our state CHILD SAFE!!!

--A message from the State Medical Society of Wisconsin

GUN SAFETY CHECKLIST

KEEP WISCONSIN KIDS BULLET-FREE AND OUR STATE CHILD SAFE

At Home, Do You:

Use a trigger lock on all guns?	___ Yes	___ No
Teach your family safety rules?	___ Yes	___ No
Make sure the gun is unloaded before you store it?	___ Yes	___ No
Store gun and ammunition separately and out of sight and reach of children?	___ Yes	___ No
Think about taking a gun safety/hunter safety course?	___ Yes	___ No
Explore other means of protection (e.g., alarms, dogs)?	___ Yes	___ No
Consider removing extra guns from your home?	___ Yes	___ No

When Handling a Gun, Do You:

Use gun/trigger safety device, only unlocking it when about to fire?	___ Yes	___ No
Keep fingers off the trigger?	___ Yes	___ No
Make sure its unloaded?	___ Yes	___ No
Point in a safe direction?	___ Yes	___ No
Always forbid horseplay?	___ Yes	___ No
Not use drugs or alcohol?	___ Yes	___ No
Follow all safety rules?	___ Yes	___ No

Any "No" answers indicate serious safety hazards to you and your family that should be corrected BEFORE you handle your gun again.

Remember: Treat every firearm like its loaded!

A message from your doctor

CHILD SAFE is sponsored by the State Medical Society of Wisconsin with an educational grant from Blue Cross & Blue Shield United

New vaccine information forms needed after Oct 1

THE NEW "Vaccine for Children" (VFC) program, which began Oct 1, will use new patient-friendly information statements that do not require a patient's signature. Moreover, all public and private health care providers, regardless of whether the vaccine is purchased from public or private funds, must use the new forms unamended, due to changes in the National Childhood Vaccine Injury Act. Though the vaccine information statements do not require a patient's signature, providers must note the date it is given to the patient in the child's medical records.

The new vaccine information statements will be required after Oct 1 for use in administering the following vaccines: DPT, Td, MMR, DTaP, DT, DTP/Hib combination, and polio (OPV and IPV). The state Division of Health has mailed copies of the forms, which may be photocopied, to current Medicaid Volume Vaccine Program providers.

Physicians who have not received the forms may order them from the Wisconsin Immunization Program, PO Box 309, Madison, WI 53701. Contact persons are Jeff Berg or Fred Appleton, (608) 266-2346. Or, you may order the new forms from SMS Holdings. Price: $25 plus tax for 100 sets of the four forms (shipping included). Contact Bill Guerten: 1-800-545-0632 to order.

There will be no penalty for physicians who start administering VFC vaccines on Oct 1 without the new forms, according to Appleton of the state Division of Health. Physicians who wish to enroll must send in enrollment forms to the Wisconsin Immunization Program administrators at the above address. The enrollment deadline is Oct 1, but interested physicians may also enroll after that date if they wish.

The program's goal is to expand eligibility and access to childhood vaccinations from birth to age 18. Eligible children will receive immunizations recommended by the Advisory Committee on Immunization Practices (ACIP). The AAP immunization schedule is compatible with the ACIP schedule. Immunization schedules will also be mailed to Volume Vaccine providers with the information statements. For policy-related questions about the forms or the VFC program, call Kevin Wymore at 1-800-362-9080.❖

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

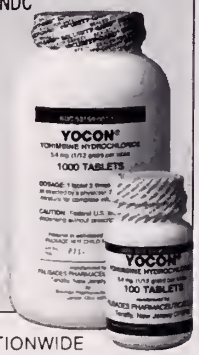
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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WIPRO encourages ideas for local improvement projects

Beginning in late 1993, WIPRO's Medicare contract activities shifted from the traditional quality assurance approach based on individual case review and intervention, to a quality improvement approach known as the Health Care Quality Improvement Program (HCQIP).

WIPRO's level of case review has been gradually declining toward a goal of about 1% of Medicare discharges by the end of the year. Resources have been shifting to the development and implementation of cooperative improvement projects. In these projects, WIPRO analyzes hospital Medicare data to identify quality of care variations and data are fed back to participating hospitals that can use them to improve care. By now, a number of Wisconsin physicians have experienced this new approach through their hospital's participation in the nationally directed cooperative cardiovascular project or one of WIPRO's locally developed projects, such as pneumonia, breast conserving surgery, or radical prostatectomy.

WIPRO has resources for data collection and analysis and is funded to provide a facilitation role with providers working on particular quality or use issues. WIPRO is looking for project topics and ideas for how physicians and hospitals think its resources and skills can be most useful to them. Ideas can be submitted to Jay A. Gold, MD, JD, MPH, principal clinical coordinator, WIPRO, 2909 Landmark Place, Madison, WI 53713 with copies sent to Anne Bicha, SMS health policy analyst, State Medical Society, PO Box 1109, Madison, WI 53701. Additional information about the HCQIP process can be obtained from the May 1994 issue of the *Wisconsin Medical Journal*, pages 219-222.❖

Physician briefs

The *indicates a member of the SMS

Mark Boettcher, MD, a specialist in pediatrics and adolescent medicine, recently joined the staff at Dean Medical Center. He will be seeing patients at the Riverview Clinic in Janesville, and the Delavan Clinic. Dr Boettcher received his medical degree from the University of North Dakota School of Medicine, and completed his residency in pediatrics at the University of Wisconsin.

Miriam P. Cope, MD,* recently joined the staff of the Hartland Clinic. Her practice will include family medicine, including obstetrics. Dr Cope completed her residency in family medicine at St. Mary's Hospital in Milwaukee and is a 1991 graduate of Rush Medical College of Chicago.

Steven Giles, MD,* of Moreland Family Medicine Associates SC, has been nominated to serve as a member of the Olympic Medical Support Group for the 1996 Olympic Games in Atlanta. He has been serving the Waukesha community as a family

Continued on next page

Residents may apply for AMA leadership award

The 1995 AMA/Burroughs Wellcome Co. Leadership Awards are now taking applications for resident physicians who wish to attend one AMA annual and interim Meeting. Winners will have their expenses paid to attend the meeting at which the grant will be presented. For information or an application, call resident physician services at the AMA, (312) 464-5596. The deadline is Jan 13.❖

Continued from preceding page
practice physician with special interest in sports medicine for more than 15 years.

David Henningsen, MD,* a family practitioner, has joined the staff of Marshfield Clinic-Indianhead Center. He recently completed his residency in family practice at St. Francis-Mayo in La Crosse. He received his medical degree from the UW School of Medicine in Madison.

Cyril "Kim" Hetsko, MD,* a past president of the SMS, has been elected a trustee of the National Commission of Office Laboratory Accreditation in Washington, DC. The commission is a joint activity of the AMA and several medical specialty societies that accredits physician office laboratories across the nation. Dr Hetsko is also now on the editorial advisory board of the *Internal Medicine News.*

Thomas Isaacson, MD,* recently joined the staff of Midelfort Clinic and Luther Hospital. Dr Isaacson is a cardiologist. He received his medical degree from the University of Illinois College of Medicine, Chicago. Before performing his residency in internal medicine at the University of Iowa Hospital and associated clinics in Iowa City, he received additional training in the treatment of heart disease at the Southern Illinois University School of Medicine in Carbondale, Ill.He also completed a 3-year cardiology fellowship at the University of Minnesota, and most recently finished an interventional cardiology fellowship through the University of Minnesota-affiliated hospitals. He is board certified in internal medicine and cardiology.

Cary J. Kohlenberg, MD, a psychiatrist from Elm Grove, has joined the medical staff at Waukesha Memorial Hospital. A graduate of the University of Wisconsin-Madison, he recently established his psychiatric practice at ICF Consultants in Brookfield. Prior to joining the hospital staff, he served as chief psychiatrist for Waukesha County.

Kristie Leong, MD,* a family practitioner, has joined the staff of the Redi-Med Medical Center in Wauwatosa.

Raul Mateo, MD,* has joined Heritage Square Healthcare Centre as medical director. He is in family practice at Lakeshore Family Medicine.

Richard Menet, MD,* has recently joined the staff of Occupational Health Systems of Wisconsin, Inc. He will provide full clinical services in Appleton, Neenah, and Oshkosh. He is board certified in internal medicine and is a member of the American College of Physicians.

Franklin L. Myers, MD,* of Madison, is a Senior Honor Award recipient. He was cited for advancing ophthalmology by the American Academy of Ophthalmology. Dr Myers is in private practice.

Lester Nider, MD, has joined the Department of Internal Medicine at The Monroe Clinic. Dr Nider received his medical degree from the University of Illinois School of Medicine and completed his residency in internal medicine at the University of Illinois. He is board certified in internal medicine and geriatrics and brings more than 9 years of experience to The Monroe Clinic.

James J. Nocton, MD, of Fox Point, was named assistant professor of pediatrics at the Medical College of Wisconsin. He practices at Children's Hospital of Wisconsin.

John K. Scott, MD,* former SMS President, recently spoke on the subject of food contamination at the International Society of Doctors for the Environment World Congress and Fourth General Assembly, held in Koblenz/Rhine, Germany.**Marc Smith, MD,*** has been appointed medical director at Redi-Med Medical Center in Wauwatosa. He joined the medical staff in 1991 and moved his medical practice to Redi-Med in March of this year.

Jack Strong, MD,* was presented the first Distinguished Service Award by the Wisconsin Academy of Family Physicians, at their annual Scientific Assembly held in Oshkosh. Dr Strong has been a member of the WAFP since 1962, and has served as president, board chair, and chair of the Scientific Assembly Committee. While chairing the committee on legislative affairs, he represented WAFP to the SMS Governmental Affairs Commission and to the Medicare and Medical Assistance Technical Advisory Committees. Dr Strong currently is fulfilling the term of the governor's appointment to the Wisconsin Patient's Compensation Fund. He has served as assistant Clinical Professor with eh UW Department of Family Practice and has been an instructor in clinical medicine since his retirement from family practice in Mauston in 1986.

Peter Szachnowski, MD, joined the Monroe Clinic as a specialist in rheumatology. He completed his residency in internal medicine at Flushing Hospital Medical Center in Flushing, NY, and received his fellowship in rheumatology from the University of Wisconsin-Madison. He is board certified in internal medicine.

Michael M. Uy, MD,* recently joined the staff at the Hartland Clinic, providing family medicine including obstetrics. He completed his residency at the St. Francis-Mayo Family Practice Residency in La Crosse and is a 1991 graduate of the UW

School of Medicine in Madison.

Peter Wagner, MD, a general internal medicine specialist, has joined Midelfort Clinic. A graduate of St. Olaf College in Northfield, Minn, Dr Wagner received his medical degree and performed his residency at Mayo Medical School in Rochester, Minn. Before joining Luther/Midelfort, he was in private practice in Muskegon, Mich. He is board certified in internal medicine and geriatric medicine.

Jay B. Winston, MD, of Brown Deer, has joined the staff at St. Francis Hospital and has been named medical director for the hospital's mental health unit. He is in private practice in psychiatry at the Winston Clinic, and serves as director of the partial hospitalization program at CPC Greenbriar Hospital. He received his osteopathic medical degree from the University of Osteopathic Medicine and Health Sciences in Des Moines, Iowa and completed his internship in familypractice at Milwaukee's Lakeview Hospital. He served his residency at the University of North Carolina in Chapel Hill. He recently completed a fellowship in forensic psychiatry at the Federal Correctional Institution in Butner, NC.

Leonard Worman, MD,* of Wauwatosa, a retired thoracic surgeon and member of the original medical staff at Elmbrook Memorial Hospital, has been named to serve on the board of directors for the International Association of Laryngectomees. He has certification from the American Board of Surgery, Board of Thoracic Surgery and the American Society of Addictive Medicine.

Anna Marie Windsor, MD,* has joined the OB/GYN practice of Roley, Anderson & Melius, Ltd.

Mohamed Yafai, MD,* a board certified internal medicine specialist, joined Mercy Delavan Medical Center's staff. He comes to Walworth County from Milwaukee, where he worked in a group practice and was an assistant professor of medicine and director of general medicine consultation service at the UW Medical School, Milwaukee clinical campus. Dr Yafai is a graduate of Long Island University in Brooklyn, NY. He completed an internship and residency at West Suburban Hospital Medical Center in Oak Park, Ill.

James M. Yohanan, MD,* a Mayo Clinic-trained ear, nose and throat specialist, will join the medical staff of the Mercy Walworth Medical Center. A Wisconsin native, Dr Yohanan is a graduate of the UW Medical School in Madison. He completed an externship at the University of Sydney Medical School in New South Wales, Australia, while attending the UW. He served his internship in general surgery and residency in otohinolaryngology at Mayo Clinic in Rochester, Minn. He most recently worked as an instructor and chief resident associate at the Mayo Medical School.❖

County society news

Brown. The Brown County Medical Society met in Green Bay at the Holiday Inn City Center, on September 8, 1994. Mary Ellen Williams, MD, spoke on the emotions of a physician. Membership was approved for Christopher Van Saders, MD; Robert Monette, MD; Gunar Ronald Strungs, MD; Peter Holzwarth, MD; Richard Potts, DO; Daniel Degrout, MD; James Orear, DO; Joe Cullen, MD; and Timothy Cooper, MD.

Chippewa. New members accepted into the Chippewa County Medical Society include: James K. Bieging, MD; Chris R. Longbella, MD; Michael H. Walton, MD; and Margaret A. Zander, MD.

Clark. New members accepted into the Clark County Medical Society include: Deja Angsurat, MD; Teodorico Y. Asinas, MD; and Apolinar E. Jovellana, MD.

Dane. The Dane County Medical Society has approved membership for the following physicians: Jeffrey Anders, MD; Nicholas Armstrong, MD; Bret Borowski, MD; William Bridson, MD; Rebecca Byers, MD; Thomas Casper, MD; James Couser, MD; Michael Gebetsberger, MD; Mark Goldsworthy, MD; Mark Halstead, MD; Gregory Hartig, MD; Rudolph Hecht, MD; Barbara Horner-Ibler, MD; Christopher Inglese, MD; James Johnston, MD; Richard Kacher, MD; Robert Kerwin, MD; David Kim, MD; Jeffrey Knuppel, MD; Raymond Jame Kotwicki, MD; Kevin Kuntz, MD; Maureen Lavin, MD; Margaret Little, MD; Daniel Malone, MD; Kimberly Messer, MD; Stephan Miller, MD; Kim Murphy, MD; Laura Murvar, MD; Glenn Nickele, MD; James Nosal, MD; Pamela Olson, MD; David Onsager, MD; Ants Palm-Leis, MD; Daniel Paulson, MD; Denise Prehn, MD; Ann Ruscher, MD; Susan Scott, MD; Eric Stecker, MD; Nasreen Syed, MD; Barbara Szachnowska, MD; and Stephen Wagner, MD.

Continued on next page

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Green Lake/Waushara. Dr Allen Chantelois has been approved for membership in the Green Lake Waushara County Medical Society.

Jefferson. The Jefferson County Medical Society approved membership for Marc H. Erickson, MD; Steven P. Rhodes, MD; and Charles J. Walker, DO.

Kenosha. The Kenosha County Medical Society approved membership for the following physicians: Paul V. Capelli, MD; Majed Jandali, MD; Bernard Lakemaker, DO; James M. Schoening, MD; Hilary J. Webster, MD; Michael C. Kreager, MD; Nina Kayeum, MD; Gregory J. Gullo, MD; Clarence P. Abella, MD; and Ashokkumar N. Shah, MD.

Outagamie. New members approved by the Outagamie County Medical Society include: Mark J. Chelsky, MD; Christopher R. Pfaendtner, MD; DeeAnn D.B. Reece, MD; William H. Reed, III, MD; and Rich W. Stoughton, MD.

Racine. The Taylor County Medical Society approved membership for Dr James H. Taylor.

Sawyer. The Sawyer County Medical Society approved membership for Andrea J. Carroll, MD; Nina J. Gilberg, MD; Kathy J. Keimig, MD; and Ali H. Mardan, MD, PhD.

Sheboygan. The Sheboygan County Medical Society approved membership for LoriBrooks, MD; Michael Brooks, MD; Paul Tuttle, MD; Jeffrey Britton, MD; Catherine Best, MD; and Adel Yaacoub, MD.

Taylor. Susan J. Frazier, MD, has been approved for membership in the Taylor County Medical Society.

Walworth. The Walworth County Medical Society approved membership for James M. Yohanan, MD; and Mohamed H. Yafai, MD.

Waukesha. The following physicians have been approved for membership in the Waukesha County Medical Society: Paul Mannino, MD; Mark A. Schultz, DO; Brian Lipman, MD; Gerard G. Adler, MD; Todd Doenier, MD; Joy Rynda, MD; Michele R. Tschopp, MD; Michael Uy, MD; James Bartlett, DO; Evelyn Kase, MD; Kris Gendreau, MD; Paul Cotton, MD; Christine Pooler, MD; John R. Zandt, MD; and Richard A. Moran, DO.

Winnebago. The Winnebago County Medical Society approved membership for Govindaraju Subramani, MD; and Chaker Dahan, MD.❖

RPS seeks active participants

The SMS Resident Physicians' Section (RPS) is looking for residents who wish to control their professional destiny. The RPS Governing Council has set goals for the next year and is ready to move forward in addressing the needs and listening to the opinions of residents across Wisconsin.

Key objectives are: obtain one active RPS member from each residency program in the state; increase resident participation in the RPS; have RPS members seated on each of the state and county commissions; increase resident contribution to the main body of the SMS; and obtain a YPS mentor for the RPS. Nationally, the RPS wants to increase the number of resident physicians attending the AMA annual and interim meetings and submit resolutions to the AMA-RPS.

To get involved in opening the doors to your professional future, call Anne Rittman at 1-800-362-9080 (outside Madison) or 257-6781 (in Madison).❖

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CES Foundation donors

The individuals and organizations named below made contributions to the Charitable, Educational and Scientific Foundation from March-September 1994.

Beaumont 500 Club
In recognition of those individuals, county medical societies, alliances who contribute their support to the Fort Crawford Medical Museum.

Dr and Mrs Charles Pechous, Jr., MD

Fort Crawford Medical Museum Capital Improvement Fund
The individuals named below made contributions to the Charitable, Educational and Scientific Foundation for the Fort Crawford Medical Museum Capital Improvement Fund.

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Dr and Mrs Robert Baldwin
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Dr and Mrs William Treacy
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Edward W. Vetter, MD Medical Education Scholarship Fund
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Earl and Alice Thayer Lecture Fund
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Fort Crawford Medical Museum General Fund
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Outagamie County Medical Society

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Green County Student Loan Fund
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Dr and Mrs William A. Smullen
Robert J. Starshak
Doctors Brian and Joan Wake
Margart C. Winston, MD
Herbert J. Zimmers, MD

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Dane County Medical Society
Julie A. Hein
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Theodore A. Praxel, MD
Riverview Hospital Medical Staff
Dr and Mrs Robert T. Schmidt
State Medical Society of Wisconsin
Patricia J. Stuff, MD
Earl and Alice Thayer

In Memoriam
In loving memory of those individuals who will grace our paths forever.
Robin N. Allin, MD
John M. Anderson, MD
Max O. Bachhuber, MD
Roy B. Balder, Jr., MD
Carroll Bauer, MD
Harry Bauman
William A. Brah, MD
Alice David Cantwell
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Continued on next page

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Robert L. Temple, MD
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The individuals named below made contributions to the Charitable, Educational and Scientific Foundation through the SMS membership dues statement from February - September 1994.

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NATIONWIDE OPPORTUNITIES: East and west coasts, Midwest, Hawaii...we have excellent practices available in single/multi-specialty groups, hospital, clinic or solo positions. Our clients are offering outstanding compensation packages to qualified BC/BE physicians. Current Wisconsin and Illinois practice needs: IM, FP, OB, PD, OTO, GS, NEP, ORS, CD, ON, D, P-Natol, and OM. Send CV or call Suzanne Foreman; 1-800-723-6517/MED SEARCH, INC., 8405 W. Forest Home Avenue, Suite 104, Milwaukee, WI 53228. Fax 1-414-529-4243. 10/94

JANESVILLE, WISCONSIN - URGENT CARE: Riverview Clinic, a division of Dean Medical Center, is actively recruiting an urgent care physician to join its medical staff. We recently increased our compensation package which is based on a 40 hour work week. Total compensation for Year 1 - $108,000.00, Year 2 - $134,642.00 and Year 3 - $135,000.00. We currently have two physicians which staff the clinic from 9:00 a.m. - 9:00 p.m. Monday through Friday and 9:00 a.m. - 11:30 a.m. on Saturday and desire to expand the hours of operation until 9:00 p.m. on Saturday and 1:00 p.m. - 9:00 p.m. on Sunday. Our facility is brand new and well equipped with 8 exam rooms, lab and x-ray. Flexible hours are available with an expected total of 30-40 hours per week. Excellent compensation and benefits are provided. For more information contact Scott M. Lindblom, Dean Medical Center, 1808 West Beltline Highway, Madison, WI 53713, (work phone) 1-800-279-9966 or (608)259-5151, FAX (608)259-5294,(home phone) (608)833-7985. 10-11/94

SOUTHERN WISCONSIN - Dean Medical Center seeks 3rd neurologist for regional office. Opportunity to pursue sub-specialty interests (pediatrics a plus). Proximity to Madison, Milwaukee and Chicago. Strong economic climate, exceptional schools, affordable housing. Call or send C.V. to Jane Vogt, 800-765-3055, 222 S. Central, Suite 700, St. Louis, MO 63105, FAX 314-726-3009. 10/94

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INTERNAL MEDICINE OR FAMILY PRACTICE PHYSICIAN needed to do mostly office work and some hospital work. Competitive salary and good benefits. Send CV to Merrill Medical Associates, S.C., 716 East Second Street, Merrill, WI 54452. Or call: (715) 536-2463. 6,8,10/94

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9-11/94

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8-12/94

Physicians Exchange

Continued

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WISCONSIN: Family practitioner-Internal medicine needed by a growing practice of a four physician group in a friendly rural community in Northeast Wisconsin near Green Bay. This is an excellent opportunity to join an established organization. Highly competitive salary with benefits. Please contact: Artwich Clinic, Oconto Falls, Wisconsin 54154. 9/94-5/95

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NATIONWIDE - Opportunities for the following: IM, FP, OB/GYN, PED, ONC, CD, and more. Send CV to Stan Kent, Stan Kent & Associates, P.O. Box 904, Tremont, IL 61568, or call 800-831-5679, FAX 309-925-5842. 5-12/94

JANESVILLE, WISCONSIN: Dean Medical Center, a 300 physician multispecialty group, is actively recruiting additional BE/BC family physicians to practice at the Riverview Clinic locations in Janesville, Milton and Delavan, Wisconsin. Traditional family practice and urgent care opportunities are available. Janesville, population 55,000, is a beautiful, family oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. Send C.V. to Stan Gruhn, MD,

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8-12/94

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Mary Gavinski, MD
Medical Director
Community Care for the Elderly
5228 W. Fond du Lac Avenue
Milwaukee, WI 53216
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10-12/94

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Wisconsin Physicians working in Wisconsin.

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8-10/94

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Physicians Exchange

Continued

Riverview Clinic, P.O. Box 551, Janesville, WI 53547 or call (608)755-3500. An Equal Opportunity Employer. 10-12/94

GENERAL SURGEON/FAMILY PRACTICE/OB-GYN/INTERNAL MEDICINE to join progressive 13-physician group practice. Rural college town 30 miles from St. Paul, MN. New clinic and new hospital. Contact Robert B. Johnson, MD, River Falls, WI 54022. 715-425-6701. 8/94-1/95

FAMILY PRACTICE physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St. Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice quality care in good recreational area. Send CV to James A. Volk, MD, Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 8-12/94

JANESVILLE, WISCONSIN - ADULT NEUROLOGY/CHILD NEUROLOGY: Riverview Clinic, a division of Dean Medical Center, is actively recruiting a BE/BC adult or child neurologist to join their medical staff of 2 BC adult neurologists. Excellent compensation and benefits are provided. Janesville, population 55,000, is a beautiful, family oriented community with excellent schools and abundant recreational activities. Excellent compensation and benefits are provided with employment leading to shareholder status. For more information contact: Scott M. Lindblom, Medical Staff Recruiter, Dean Business Office, 1808 West Beltline Highway, P.O. Box 9328, Madison, Wisconsin, 53715-0328, work toll-free 1-800-279-9966 or (608)259-5151, home (608)276-8989 or FAX (608)259-5131. 10-12/94

FAMILY PRACTICE PHYSICIAN needed to join established group of five FPs and one Pediatrician. Northwestern Wisconsin community of 8,000 with service area of 40,000, located on the doorstep of Wisconsin's fabulous lake country. Practice medicine in a small family-oriented community within two hours of Minneapolis/St. Paul. Competitive salary and excellent fringe package. Send CV to James A. Volk, MD, Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 8-12/94

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THE WAUSAU MEDICAL CENTER is seeking Board Certified-Eligible individuals in the following specialties: Internal Medicine, Family Medicine, Obstetrics/Gynecology, Occupational Medicine and Urology. Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefit plan and profit sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year round. Write or call collect David K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wisconsin 54401, telephone (715) 847-3235. 2/93;TFN

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* several opportunities
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Madison, WI 53703
or call collect: (608) 252-8580

1-12/94

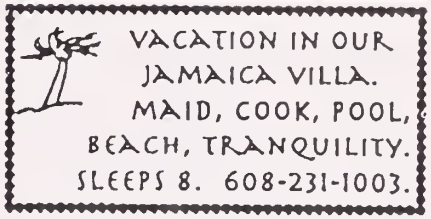
State Medical Society of Wisconsin

Date and location of
1995 ANNUAL MEETING

April 7-9
Grand Geneva Resort & Spa

Further information: Call the SMS Meetings Department. Local Telephone: 257-6781; toll-free: 1-800-362-9080.

Miscellaneous



9-12/94

Medical Meetings-Continuing Medical Education

AMA

December 4-7, 1994: Interim House of Delegates, Honolulu.

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Peppino's Restaurant 505
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Pro Services 519
SMS Insurance Services, Inc. .. IFC,507
US Air Force 536
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10. Owner *(If owned by a corporation, its name and address must be stated and also immediately thereafter the names and addresses of stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Do Not Leave Blank.)*

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PS Form 3526, October 1994 *(See Instructions on Reverse)*

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17. Signature and Title of Editor, Publisher, Business Manager, or Owner — Date

Russell Kri — 9-21-94

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions *(including fines and imprisonment)* and/or civil sanctions *(including multiple damages and civil penalties)*.

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2. Include in items 10 and 11, in cases where the stockholder or security holder is a trustee, the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check box. Use blank sheets if more space is required.
3. Be sure to furnish all information called for in item 15, regarding circulation. Free circulation must be shown in items 15d, e, and f.
4. If the publication had second-class authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or the first printed issue after October, if the publication is not published during October.
5. In item 16, indicate date of the issue in which this Statement of Ownership will be printed.
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PS Form 3526, October 1994 *(Reverse)*

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Through the years, the CES Foundation of the State Medical Society (CESF) has been devoted to the promotion of medicine in Wisconsin. A commitment to preserving the history of medicine is also evident through the Fort Crawford Medical Museum. In order to preserve the mission of the CESF and build an endowment for the future — we need your support.

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With your generosity, you can support your medical profession plus receive a lifetime income. How? Through a planned giving opportunity known as a Pooled Income Fund.

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For a personal prospectus, contact Julie Hein in the Foundation office at 1-800-362-9080.

Hospital Medical Staff Section
24th Assembly Meeting
December 1-5, 1994
Sheraton Waikiki Hotel
Honolulu, Hawaii

Representation Education and Networking

Send a representative from your hospital medical staff and physician organization to the 1994 Interim American Medical Association Hospital Medical Staff (AMA-HMSS) Assembly Meeting held on December 1-5 in Honolulu. Aside from participating in the development of AMA policy, representatives will have an opportunity to network with colleagues, dialogue with the AMA Board of Trustees, and hear the latest news and information on health system reform.

With a changing health care environment, broader diversity within the physician population, limited resources, and an overriding need for unity of purpose and action by organized medicine, the AMA has undertaken a study of the Federation.

Federation Consortium Study

The study, involving county, state and specialty societies, the AMA, and other related organizations, intends to uncover useful information for developing ways to increase membership, member participation, and advocacy as well as improve communications, medical society performance, and resource utilization.

Project leaders have asked the AMA-HMSS to participate in the process because it effectively represents grassroot physician concerns. Input from each HMSS representative also will be extremely valuable in defining organized medicine in the future.

The 1994 Interim AMA-HMSS Assembly Meeting Education Program will host the Consortium study. Data collected and analyzed will facilitate the following objectives:

- Identify current and future needs, expectations, and preference of physicians and others for organized medicine;
- Explore membership ideas and options;
- Assess how medical societies relate to each other—including ways to be more supportive, avoid duplication of effort, leverage strengths, and better address weaknesses;
- Discover whether there are better tools/technologies that medical societies can use to communicate with one another and their members; and
- Enable medical societies to work smart in a more focused and purposeful way.

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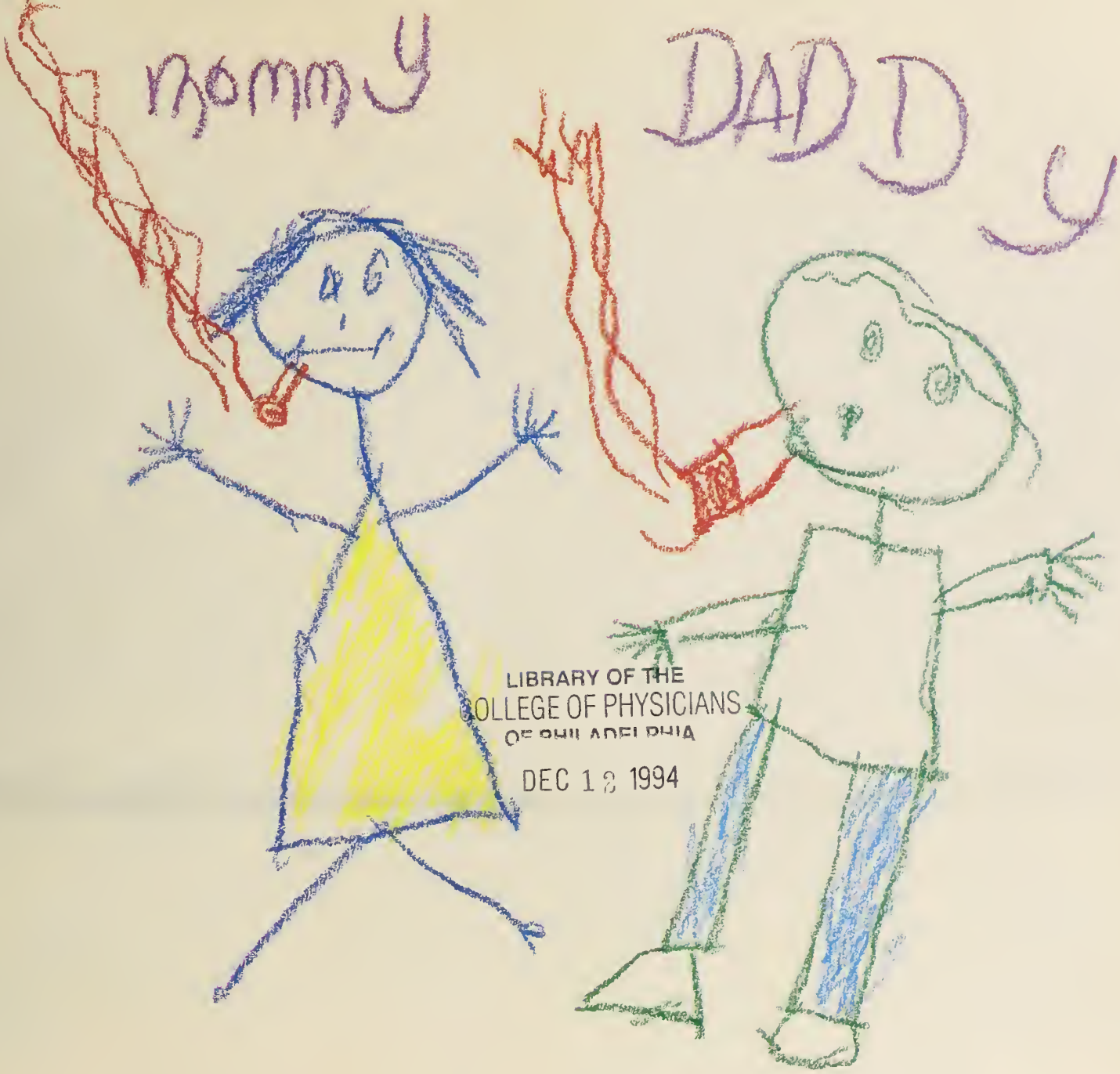

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Contents

November 1994 Vol. 93 No. 11

Opinions

557 *President's page*
Ciphering the new alphabet: Rx for APN
by Richard G. Roberts, MD, JD, Madison

561 *EVP report: The view from here*
Neither Rome nor the SMS was built in a day
by Thomas L. Adams, CAE, Madison

563 *Editorials*
Primary care and nurses
by Richard D. Sautter, MD, medical editor

564 *Letters*
We need both enthusiasm and wisdom
by William B.A.J. Bauer, MD, Ladysmith

565 The physician is sick
by Carl J. Chelius, MD, Cudahy

565 Comments of the CHILD SAFE program
by John E. Walz, MD, Columbus

566 Friend or foe?
by Duane M. Koons, MD, Viroqua

567 *Soundings*
Revenge
by George W. Kindschi, MD, Monroe

Socioeconomic

569 *Public health*
The health care burden of cigarettes on Wisconsin communities, 1994
by Thomas J. Van Gilder, MD and Patrick Remington, MD, MPH, Madison

573 Is your waiting room reading material promoting tobacco use?

578 The daily burden of smoking in an average Wisconsin community
by Richard A. Yoast, PhD, Madison

582 Attitudes of the Wisconsin State Legislature toward tobacco control policies
by Robert Gifford and Marge S. Brindley, MS, Milwaukee

585 Tobacco acquisition practices of adolescents in two Wisconsin communities
by Joseph Cismoski, MPH, and Marian Sheridan, RN, Fond du Lac

591 Blinded by the light: The folly of tobacco possession laws against minors
by Joseph Cismoski, MPH, Fond du Lac

Organizational

601 Nominating Committee compiles slate of candidates;
Dr Ulmer nominated for 1995 president elect

601 AMA seeks recommendations for committee appointments

602 Physician briefs

602 Medical students hear of need for involvement

604 County society news

605 SMS requests hearing on nurse prescribing rules

606 Making the most of your charitable giving through the PIC-Wisconsin matching grant program

606 AMA awards

Our cover: From the American Heart Association. Our theme articles are indicated by this symbol

Wisconsin Medical Journal

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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal*.

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President's page

Ciphering the new alphabet: Rx for APN

On March 8, 1994, the Legislature enacted 1993 Wisconsin Act 138, which permits advanced practice nurses (APN) to prescribe drugs. APNs include certified registered nurse anesthetists, certified nurse midwives, nurse practitioners, and clinical nurse specialists. This new independent prescribing authority for nurses has sparked considerable conversation, especially among physicians. The following reviews the politics, the problems, and the possibilities regarding this expanded scope of nursing practice.

The politics

In the spring of 1993, I was one of several SMS representatives who participated in discussions on health reform with members of the legislature and administration and with leaders of various nursing groups. The purpose of the meetings was to consider proposals for health reform, including one that would have created statutory authority for a new type of nurse: a primary care nurse. This nurse would have been able to provide, in an under-served area, a wide range of services approximating those of a physician. In effect, the proposal suggested that a nursing license, which could be obtained with as few as 2 years of training after high school, was equivalent to a medical license, which required 4 years of college, 4 years of medical school and 1 year of internship--equivalent, that is, if the patient had the misfortune of residing in an under-served area. Moreover, the proposal would have compelled a physician to enter into a collaborative relationship with a primary care nurse when demanded by such a nurse, or risk a claim of unprofessional conduct and loss of license.

Richard G. Roberts, MD, JD

The proposal was a dumb idea. It was opposed vigorously by the SMS representatives *and* by the nursing leaders. Looking back, it is easy to dismiss such a proposal and to wonder how it could have been considered seriously in the first place. It must be remembered that these discussions took place against the backdrop of the health system reform

Continued on next page

debate with its focus on improved access and reduced costs and a new president's commitment to nursing. The other political fact was that the speaker of the Assembly and the chair of the Assembly Health Committee were nurses intent on doing something for nurses. It looked like it was going to be a long and difficult legislative session--and it was.

Out of the meetings on primary care nursing grew momentum for independent prescribing authority for nurses. Some physician groups supported *limited* prescribing authority for nurses, believing that it would correct the charade of supervising physicians having to countersign each and every prescription for their nurse practitioners. Mindful of the reality that something was going to pass, the SMS endeavored to shape the bill to better protect the needs of patients. We insisted on evidence of adequate training in prescribing and of ongoing relationships with physicians so that patients could access readily the rest of the health system when problems arose. Having made good faith attempts to shape the bill into a better one, the official position of the SMS on the proposed legislation was no position--that is, the Board of Directors neither supported nor opposed the final product: 1993 Wisconsin Act 138.

The Act directed the Board of Nursing to promulgate rules specifying the educational requirements, scope of practice, classes of drugs and malpractice coverage for the APN who seeks prescribing authority. The secretary of the Department of Regulation and Licensing (DRL), who also happened to be an LPN, was obliged under the law to establish an advisory committee consisting of 4 nurses, 3 pharmacists, and 3 physicians. The committee was to advise the DRL and t h e Board of Nursing in drafting the rules necessary to carry out the intent of the legislation.

The advisory committee met five times during the spring of 1994. The most important provisions, educational requirements and collaborative relationships, were also the most difficult for the advisorycommittee to resolve. Many observers felt that the committee's eventual proposed regulations, while perhaps the best compromise that could be achieved given the composition of the committee, failed to meet the Legislature's intent or the needs of patients. During the summer, hearings on the recommended language were held across the state. A number of physician groups, including the SMS, offered testimony expressing their concern with the advisory language. On Oct 25, 1994, the Board of Nursing released the draft rules, which were changed minimally from those recommended by the advisory committee.

The problems

The draft rules remain deficient in several areas: inadequate educational requirements and insufficient guidance on collaboration. The rules would require 30 hours of pharmacology training and a master's degree in nursing or a related health field by the year 2002. The SMS believes that the critical educational determinant should be the amount of supervised training in the clinical setting while prescribing for patients, not a one-semester, 3-credit course in pharmacotherapeutics and a master's in health administration!

The collaboration issue is a contentious one for nurses who are quick to remind physicians that they have an independent license and that physicians are not required by law to collaborate. Both contentions merit a response. While nurses are licensed independent of physicians, the Wisconsin Statutes indicate that a nurse executes certain "procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician. . ." (s. 441 .1 1 (4)). Further, Board of Nursing Rule 6.03(2) specifies that an RN shall perform delegated medical acts under the supervision of a physician.

The argument that nurses should be able to prescribe independently of physicians because they are licensed independently begs the question. Prescribing *is* a medical act, hence the need for the new legislation permitting independent prescribing by nurses. The legislation directed that rules be developed which specified how nurses and physicians would collaborate.

Physicians are obliged to collaborate in the care of patients. Medical malpractice case law, hospital quality assurance committee decisions, WIPRO reviews, and a several thousand year tradition of consultation are but a few of the safety mechanisms physicians have developed to assure that a patient has timely access to the full range of needed medical services. Such mechanisms are not in place for prescribing nurses. Thus, specific regulatory language is needed to implement this newly awarded statutory privilege.

The possibilities

Several options are available to reshape the draft rules. The Legislature can hold oversight hearings and direct the Board of Nursing to modify the draft rules to better meet legislative intent. A Senate hearing will be held at the end of November. Another series of options could include future legislation that would further limit, sunset, or terminate a nurse's statutory right to prescribe.

Amid the political posturing, doctors and nurses would be well advised to listen to each other. Physicians must recognize the professional respect due nurses and acknowledge that advanced practice nurses bring important new skills to the care of patient. Nurses must be willing to listen to doctors' concerns about the further fragmentation of patient care across a panoply of providers and to consider that they "may not know what they don't

know" when it comes to taking on the around-the-clock responsibilities of deciding diagnosis and therapeutics. Physicians spend a long time in a supervised clinical training continuum learning to prescribe. To prescribe with less training assumes that nurses are innately brighter than physicians and learn it all faster or that much of medical training is superfluous and unnecessarily long. There is no evidence to support the first point; on the second point, the public is not clamoring to shorten the training or qualifications of physicians!

At one extreme, we could do as some countries have done and eliminate entirely any barriers to prescription medications by allowing the patient to pull drugs right off the shelf. At the other extreme, we could limit the prescribing of medicines to very narrow groups of professionals (eg, only oncologists prescribe chemotherapy).

The proper balance between quality of care and access to care must be struck. We must be wary of the intuitively appealing argument that nurses will work where doctors will not go and that they will work cheaper. First, nurse practitioners tend to aggregate in urban settings--only 15% were in non-metro areas compared to 37 % of family physicians (and 30 % of the general population). Second, nurses will claim rightly that they should receive equal pay for the same service--so where are the cost savings?

The sad irony in all this is that the rhetoric obscures the reality. Physicians and nurses practice interdependently, not independently. It will be unusual for nurses to practice independently for the same reasons that doctors rarely practice independently--the economics of practice and reimbursement pull us together into larger organizations. The specter of armies of prescribing nurses hired by corporate or insurance monoliths providing fragmented care with inadequate coverage and insufficient linkages to the rest of the health system should give patients and policymakers pause. The draft rules must be improved.❖

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EVP report: The view from here
Neither Rome nor the SMS was built in a day

PHYSICIANS IN THE Madison media market have been exposed over the past few months to a number of news articles on the efforts of developers, John Tye and John Petersen to construct a headquarters facility for the Famous Footwear Corporation on property owned by the State Medical Society. The SMS Board of Directors had approved selling 6.2 acres of land located on the south shore of Lake Monona, adjacent to our headquarters building for that purpose.

How the Society came to own that property has an interesting history--and it made good business sense for nearly half a century. How the property will be disposed of in the future is also of interest, and I will discuss that as well.

Thomas L. Adams, CAE

The SMS was originally headquartered in Milwaukee. It was relocated to Madison in the 1940s and occupied several locations, including what is now known as the Collins House Bed & Breakfast on the south shore of Lake Mendota on East Gorham Street. In the early 1950s, the Society purchased its current site at 330 E Lakeside St, and in 1955 constructed the first phase of its headquarters.

The current site was notable for being low and marshy and, in fact, contractors had a difficult time excavating the basement, due to seepage, through very fine sand, of water from Lake Monona. The main building was constructed in 1955 using plans modified from a design for an elementary school building. Charles Crownhart was secretary (EVP) of the Society at that time and Dr N. A. Hill, Dr H. Kent Tenney, Jr. and Dr E. M. Dessloch served on the building committee.

As the Society added new activities, it needed more space. A west wing addition was added in early 1960 to house Wisconsin Physicians Service (WPS) that at that time operated as a committee and wholly owned subsidiary of SMS. At its zenith, the current buildings housed 250 employees who ate lunch in three shifts in the cafeteria. Currently, the buildings house about 100 SMS employees and space is rented to a tenant, Devenish Associates, Inc., an interior design firm.

The Society's need for space has drifted up and down over the years, necessitating the need to rent part of our building to other tenants, including: WPS, the Visiting Nurse Service, Physicians Insurance Company of Wisconsin, SMS Holdings Corporation, and Devenish Associates, Inc. We maintain a cafeteria to provide hot food service for our commissions and staff and maintain more than 5,000 square feet of meeting space in the buildings.

The buildings are located in a residential area and were permitted to be constructed by the city through a "spot" zoning change granted to the Society by the City of Madison. That change, which was opposed by the neighborhood, allowed a "not-for-profit health-related organization, doing business primarily through the mail," to locate on the site. That language gave SMS great difficulty in attracting tenants who could legally occupy the building.

In 1992, the Society approached the city to change the zoning from the spot zoning above to an 0-2 (general office) designation. That change was also opposed by the neighborhood and we wound up with new "spot" zoning that allows us to rent up to 49% of the building to outside organizations or businesses.

When the Society decided to locate on East Lakeside Street in the 1950s, its Board of Directors made a decision to buy other property in the neighborhood, as it became available, for fair market value. Over the ensuing 40 years, all private property between the headquarters building and John Nolen Drive has been

purchased by the Society. The last four houses were purchased in 1994 to pull together the property needed for the Tye and Petersen project.

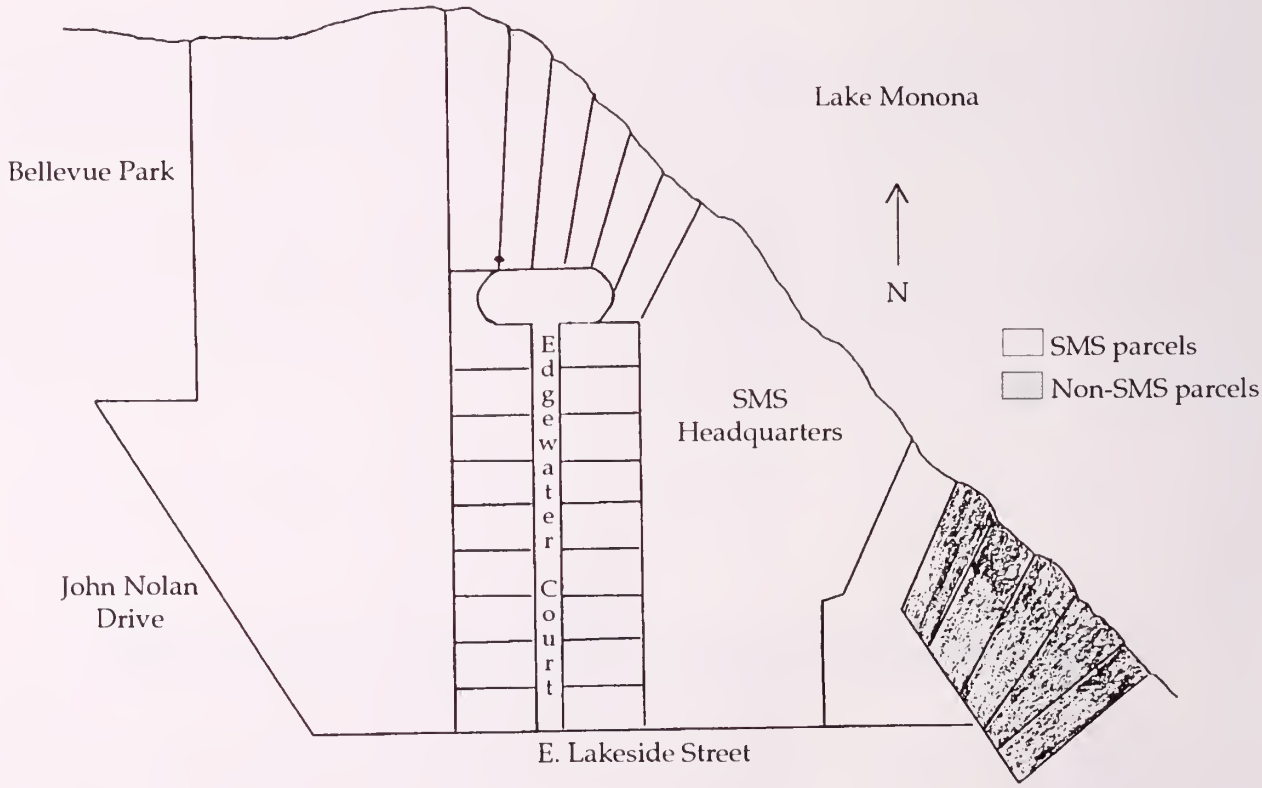
Different Boards of Directors agreed over almost half a century to make the purchases for two reasons: 1) to protect the investment in the headquarters building by controlling adjacent properties and, 2) to generate non-dues revenue by developing the property. Financially, those investments have been good revenue producers.

In 1991, with almost all the surrounding property under SMS control, the Board of Directors made a strategic decision for SMS not to participate as a developer of the site. I was instructed to market the undeveloped portion of the property to interested developers. Several options were presented for development and the Board of Directors eventually elected to sell all of its holdings west of the building (including all of its rental housing holdings) to Tye and Petersen for a new headquarters for Famous Footwear.

Local neighborhood opposition (and some support) surfaced almost immediately. It became obvious to Famous Footwear that approval from Madison's various boards and commissions was potentially going to cause serious delay in construction. Famous Footwear's principals were concerned, both over delay and some of the local neighborhood objections. When other space became immediately available on Madison's west side, Famous Footwear pulled the plug, killing the project and halting the sale of the property.

So where does that leave us? We continue to meet with city officials to determine what type of development best fits the site. There are several developers interested in the property for various projects. Most recently, the City of Madison and the Madison Metro School District have expressed interest in acquiring all of the Society's property, including the headquarters building. The Executive Committee has been authorized by the Board of Directors to negotiate a potential sale. My best guess is that 1995 will see a resolution of the use of the property.

It took over 40 years to bring the property together. It is not surprising that it will take a while to be developed.❖



Editorials
Primary care and nurses

Much has appeared in the media regarding nurses providing primary care. This idea is very strongly supported by the Clinton administration, most likely because it is perceived as a way to save money.

I have great respect for nurses, and I feel most doctors do. Without their help, it is impossible to provide even adequate care. Expert care, in very large part, depends on the quality of the nursing staff. Still, I have a problem with nurses providing primary care without physician supervision.

For many patients seeking primary or urgent care, the diagnosis is obvious. For a smaller number of patients, however, the diagnosis is elusive and requires special problem-solving skills. To be successful in making these diagnoses and determining a course of treatment, a large body of readily available background information is required: This is why we have medical schools, why medical training is long and arduous, and why "physician" is not the first career choice of the masses. The differences between the training of nurses and physicians is not insignificant.

The cost-saving argument in favor of "primary care nurses" is questionable, because the consistent pattern in scope-of-practice issues has been for the allied health professions to lobby for greater autonomy on the basis of being "cheaper" than doctors, but soon after their practices are expanded they demand to be paid as much as doctors doing the "same" work.

Differences in education and illusive cost savings are not the only concerns clouding this issue. Others, to name a few, include: malpractice, hospital admissions, charges, referrals, surgery, subspecialty designations and certification by the Medical Examining Board.

Providing care without physician supervision, nurses will be at risk for malpractice claims. I would expect that most claims would be the result of errors of omission. This is a significant risk. Recently, I was involved as an observer in a claim that was settled for more than $1 million because the attending doctor missed the patient's breast cancer. Will the nurses be covered by the state's umbrella? If not, who will provide the necessary coverage? The medical malpractice arena is already in chaos and the associated costs are uncontrollable--most likely, adding nurses to the milieu will only exacerbate the problems.

I predict that for the first few years nurse practioners will concern themselves with out-patient practices, but in the not-too-distant future they will demand the ability to admit their patients to hospitals, as the natural progression of their care.

As nurses provide more than first aid in emergencies, they will feel more and more comfortable with minor surgery. At some time, the minor surgery will require more than local anesthesia, and the nurses will enter the operating room as the surgeon. It is then a short trip to elective surgery, perhaps even a D&C. As most nurses are female, this will seem quite natural to many, as well. But this would be only the camel's nose under the tent. The next step would likely be breast surgery, followed by the pelvic organs.

Who will certify these nurse practitioners? The MEB? A new board? And what will be the requirements? Subspecialty designations for nurse practitioners is already occurring.

Yes, the shortage of primary care physicians is causing some problems; no, asking nurses to fill the gap is not the correct solution. Perhaps reversing the priorities and trends of the past few generations and placing primary care physicians at the top of the compensation ladder would be a much better solution.

--Richard D. Sautter, MDMedical Editor❖

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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Letters

We need both enthusiasm and wisdom

To the editor: Thomas Adams and Dr. Roberts wrote the most thoughtful and thought-provoking articles available in the *WMJ* in a long time. The truth that each of them endorsed and underlined was made clear by their frank evidence. Each deserves a hearty thanks.

In regard to the "EVP report": Adams began on a pessimistic note with a very realistic basis. That realistic basis, however, is understandable--the pessimism that many physicians have come to know through years of fighting the paper chase; the fears that have mounted, year after year, with no hope of tort reform; and the surrounding examples of fellow physicians losing money and reputation, even when they have followed all currently accepted treatments. All physicians have suffered in the shadows of governmental interference and malpractice that hang over them.

Young medical men and women, and students, have--as yet--none of the experience that weighs heavily on their older contemporaries. Thus, they do have more optimism, they do still have their youthful vigor.

Of course, we need that optimism and vigor in medicine, just as we need them in all the various strata of society. Perhaps medicine needs them a bit more. Medicine demands more from its practitioners than does any other vocation, so it needs the optimism Adams found in the medical students.

One must (or at least, I must), therefore, contend that we need both the enthusiasm of youth and the wisdom of experience. We must not put the two views into contention. We must, instead, amalgamate them. The fusion of wisdom and enthusiasm can be a powerful force, because it can enlighten us and inspire us to pursue a powerful, long-term sagacious course....

The reality of the need to continue out fight for health system reform is clearly imminent--so let's gear our hearts and our minds to the continuing battle.

--William B.A.J. Bauer, MD
Ladysmith

Editor's note: This letter has been edited for length.❖

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The physician is sick

To the editor: Some years ago, I wrote a letter to the editor of the *Wisconsin Medical Journal* about being an angry physician. Now, at the end of my career, things are getting steadily worse and I am writing as a "sick physician," and this does not pertain to my health.

I am sick of taking care of clients as if they were buying envelopes or machine tools from me. It is degrading to my patients who come to me, trust me, confess to me and want me to treat them with dignity and in confidence.

I am sick of having my profession downgraded as a business--the bottom line of which is money.

I am sick that the Oath of Hippocrates has lost its meaning to our profession and is not observed any more. It made us a unique and noble profession once.

I am sick of having lost charity as a consequence of Medicare, which later caused the single largest increase in medical costs.

I am sick of being forbidden to extend professional courtesy to my colleagues and their families, another step by mindless politicians and strategists to control us.

I am sick of cookbook medicine and the taking away of individual healing that makes each patient special.

I am sick of reviewers with fancy suits and attaché cases. Most of them should be at the bedside taking care of patients.

I am sick of rationing and denying care which is already here with the worst to come.

I am sick of being called from hundreds of miles away by mostly cold and assuming people telling me what to do for my patients and when to discharge them.

I am sick of having my judgement questioned and being harassed by insurance companies, the state and federal governments, and other reviewers, and of having to sign my name more than 100 times a day to meaningless documents.

I am sick to have it suggested by politicians that my profession should kill the unborn and elderly. I was born and raised in Germany, and I know what happened to the inmates of mental institutions and the ethically undesireables.

Decisions over life and death should never be discussed or decided by politicians or at the government level. It must be left as a decision between patient and physician.

I am sick of having my ethics prescribed by the likes of Sen Kennedy and Rep Rostenkowski.

I am sick of the Clinton health plan, which included almost as many penalties as benefits and did not allow anybody to opt out.

Finally, I am sick of having my profession, which is mostly ethical and highly honorable, debased by unethical politicians, business lead-

Continued on next page

Comments of the CHILD SAFE program

To the editor: I'm reading the *Medigram* of Sept 20, 1994. I would like to make some comments regarding the problem with homicides, suicides, and accidents related to firearms.

The SMS is currently actively promoting awareness of the problem with firearm trauma. It published data supporting the concept that firearms in the homes are a cause for this increasing carnage. The SMS states that "this is not a gun control issue; this is a public health issue." I agree with this issue to this point.

I would urge the SMS, however, to be aware that firearms have been available in this country throughout history and the increasing violence in large part through the use of firearms is increasing dramatically by the statistics that you have published. I don't believe that I am alone in the opinion that this increase in violence is due primarily not to the availability of firearms (not new) but to the increase in the violence that children and adults are exposed to on a daily basis and to the tendency to glorify revenge and carnage.

I would like to see the SMS come out in support of firearms training to be more actively promoted in our schools and even consider marksmanship training and competition in our schools. This would do much to increase the promotion of safety courses of firearms.

I would also expect to see the SMS, if it is genuinely concerned about the trauma more than the politics of gun control, to make some statements regarding the exposure of both children and adults to glorified violence on TV and in the movies.

Thank you very much for your attention.

--John E. Walz, MD
Columbus❖

Continued from preceding page
ers, and a hostile press with the bottom line being money.

It is time that we gather our strength, fight back, quit being divided into academies, public health, and private health. We need to be independent. Only we have the knowledge and the judgement to treat diseases and make our patients feel like individuals that we care for. We must restudy the Oath of Hippocrates, live with it and never abandon those who trust us.

We must remain our patients' advocates and guard our lives, science, art, and practice against those who are in the process of destroying it.

--Carl J. Chelius, MD
Cudahy❖

Friend or foe?

To the editor: The readers of this journal may be interested to know that Wisconsin Rep Scott Klug is one of the authors of legislation recently proposed to open up the contents of the national practitioner databank to the public at large, including consumer groups, patients, and lawyers. This is the same representative featured in this journal a couple of years ago.

Along with most of his Republican colleagues, Klug opposed health care reform efforts to provide universal health care coverage to our patients, which had been a major policy goal for the State Medical Society. Despite this, he continues to receive firm backing by WISPAC.

With friends like these....

--Duane M. Koons, MD
Viroqua

Editor's note: Rep Scott Klug has also sponsored legislation supported by the SMS and the AMA, including the House "Bipartisan Bill" for health system reform and antitrust legislation.❖

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Soundings
Revenge

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No stars, no moon,
Even sunrise sheds no light
To illuminate this fight.
No winners here,
No cause celebre,
The struggle is--
Just to live
One more hour,
One more day.

One with cancer,
One without.
The lungs of each
Just balloons of air.

When comes such a fate
To be denied a breath?
'Twas a gift,
A weed no less,
With miraculous powers
To soothe, to ease, to waft away,
The worries and cares of the day,
To soon addict,
And then destroy,
The lives and dreams
Of those
Who deeply breathe
The warm blue vapors
Of the burning leaves
Of the tobacco seed.

A common cause,
A common end.
The breathing stilled,
The soul departed,
The nightmare over,
The revenge complete.

--George W. Kindschi, MD
Monroe❖

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Public health

The health care burden of cigarettes on Wisconsin communities, 1994

Thomas J. Van Gilder, MD, and Patrick L. Remington, MD, MPH, Madison

THE HEALTH AND economic burden of cigarette smoking in the United States has been well documented. Smoking is the most important preventable cause of morbidity and premature mortality in this country.[1] Wisconsin's share of this burden has been described previously in the Public Health series.[2-4] The effect at the community level, however, has not been presented. In this report, we estimate the health and economic consequences of cigarette smoking for Wisconsin counties using local, state, and national data.

Methods

A variety of data sources were used in this study. Population information was based on 1992 estimates published in *Vital Statistics*.[5] The percentage of adult smokers who currently smoke was based on 1991-1993 Behavioral Risk Factor Surveillance System (BRFSS) data. A 3-year period was chosen to allow for more stable estimates of local smoking prevalence. Smoking percentages were calculated for the five public health regions in Wisconsin. The number of adult smokers was calculated by multiplying the county's adult population by the county's regional smoking percentage.

The total smoking deaths represent the number of deaths in a given county attributable to cigarette smoking. The number of deaths in each county due to smoking-attributable disease, including cancer, cardiovascular disease, lung disease, perinatal conditions, and other deaths were taken from the 1992 *Vital Statistics*.[5] The proportion of these deaths attributable to smoking was taken from statewide estimates (42% of all lung disease deaths, 25% of cancer deaths, 18% of cardiovascular disease deaths, 6% of perinatal deaths, and 0.4% of all other deaths).[2] We then summed the deaths attributable to each of these smoking-related causes to calculate the total number of smoking-attributable deaths in a given county.

The total smoking health costs were derived from the national estimate of smoking-attributable costs for medical care of $50 billion in 1993.[1] Because Wisconsin has 2% of the nation's population, its share of the medical costs was estimated to be $1 billion for 1993. These costs include hospital expenses, ambulatory physician care, nursing home care, and prescription drugs. The county estimates were derived from the state estimate, based on the percentage of the total number of the state's smokers who resided in the given county.

Results

Over the period 1991-1993, 25% of adults in Wisconsin smoked (Table 1). Smoking prevalence varied by region from a low of 22% in the northeast, to a high of 28% in the north. Using these data, an estimated 940,555 Wisconsin adults considered themselves current smokers during that time. At the county level, the number of adult smokers ranged from 527 in Menominee County to 194,125 in Milwaukee County.

Based on county-specific mortality data, 7,357 deaths were due to

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The public health column is not reviewed by the *WMJ* editorial board. Dr Van Gilder is a preventive medicine resident with the Centers for Disease Control and Prevention in Atlanta. Dr Remington is the chief medical officer for Chronic Disease Control, Bureau of Public Health, Wisconsin Division of Health. Reprint requests to: Patrick Remington, MD, MPH, Wisconsin Division of Health, 1414 E Washington Ave, Room 251, Madison, WI, 53703-3041. Copyright 1994 by the State Medical Society of Wisconsin.

Table 1.--Health and economic burden of cigarettes in Wisconsin counties, 1994.

	Pop. (18+)	1991-1993 Percent smokers	Number adult smokers	Total smoking deaths	Total smoking county health costs
Adams	12,856	25%	3,214	28	$3,417,130
Ashland	11,718	28%	3,281	41	$3,488,407
Barron	30,105	25%	7,526	73	$8,001,921
Bayfield	10,594	28%	2,966	26	$3,153,796
Brown	146,046	27%	39,432	241	$41,924,613
Buffalo	10,035	25%	2,509	27	$2,667,307
Burnett	10,036	25%	2,509	28	$2,667,573
Calumet	24,558	27%	6,631	32	$7,049,729
Chippewa	38,324	25%	9,581	94	$10,186,535
Clark	22,565	25%	5,641	51	$5,997,786
Columbia	34,207	24%	8,210	83	$8,728,545
Crawford	11,488	24%	2,757	27	$2,931,374
Dane	288,418	24%	69,220	368	$73,595,157
Dodge	58,107	24%	13,946	136	$14,827,070
Door	19,519	27%	5,270	49	$5,603,211
Douglas	31,221	28%	8,742	81	$9,294,381
Dunn	26,256	25%	6,564	42	$6,978,855
Eau Claire	63,083	25%	15,771	115	$16,767,487
Florence	3,576	28%	1,001	8	$1,064,563
Fond du Lac	66,779	27%	18,030	134	$19,169,876
Forest	6,425	28%	1,799	15	$1,912,700
Grant	35,701	24%	8,568	82	$9,109,767
Green	22,470	24%	5,393	52	$5,733,634
Green Lake	14,140	22%	3,111	38	$3,307,408
Iowa	14,891	24%	3,574	30	$3,799,713
Iron	4,914	28%	1,376	14	$1,462,880
Jackson	12,380	25%	3,095	36	$3,290,609
Jefferson	50,267	24%	12,064	92	$12,826,549
Juneau	16,343	24%	3,922	41	$4,170,217
Kenosha	97,195	27%	26,243	200	$27,901,228
Kewaunee	13,748	22%	3,025	30	$3,215,717
La Crosse	73,472	25%	18,368	135	$19,528,887
Lafayette	11,551	24%	2,772	23	$2,947,450
Langlade	14,701	28%	4,116	38	$4,376,436
Lincoln	20,198	28%	5,655	52	$6,012,873
Manitowoc	60,574	22%	13,326	140	$14,168,523
Marathon	85,438	28%	23,923	142	$25,434,590
Marinette	30,246	22%	6,654	83	$7,074,671
Marquette	9,641	22%	2,121	25	$2,255,072
Menominee	2,397	22%	527	6	$560,669
Milwaukee	718,980	27%	194,125	1,532	$206,393,591
Monroe	26,802	25%	6,701	59	$7,123,983
Oconto	22,680	22%	4,990	53	$5,304,951
Oneida	24,885	28%	6,968	69	$7,408,176
Outagamie	104,480	22%	22,986	174	$24,438,327
Ozaukee	55,675	27%	15,032	75	$15,982,313
Pepin	5,129	25%	1,282	14	$1,363,290
Pierce	23,572	25%	5,893	36	$6,265,447
Polk	25,553	25%	6,388	66	$6,791,998
Portage	45,264	28%	12,674	71	$13,474,932

Table 1.--Health and economic burden of cigarettes in Wisconsin counties, 1994. Continued

	Pop. (18+)	1991-1993 Percent smokers	Number adult smokers	Total smoking deaths	Total smoking county health costs
Price	11,663	28%	3,266	36	$3,472,034
Racine	130,287	27%	35,177	255	$37,400,765
Richland	13,848	24%	3,324	35	$3,533,572
Rock	103,528	24%	24,847	230	$26,417,073
Rusk	10,993	25%	2,748	29	$2,921,944
St. Croix	36,761	25%	9,190	61	$9,771,089
Sauk	35,662	24%	8,559	83	$9,099,815
Sawyer	10,772	28%	3,016	28	$3,206,786
Shawano	27,642	22%	6,081	75	$6,465,584
Sheboygan	77,553	22%	17,062	168	$18,139,985
Taylor	13,456	28%	3,768	24	$4,005,804
Trempealeau	18,932	25%	4,733	47	$5,032,133
Vernon	19,061	24%	4,575	48	$4,863,765
Vilas	14,197	28%	3,975	44	$4,226,397
Walworth	58,422	27%	15,774	123	$16,770,879
Washburn	10,465	25%	2,616	31	$2,781,601
Washington	72,893	27%	19,681	103	$20,924,988
Waukesha	231,996	27%	62,639	364	$66,597,802
Waupaca	34,936	22%	7,686	109	$8,171,683
Waushara	14,986	22%	3,297	41	$3,505,291
Winnebago	108,145	22%	23,792	203	$25,295,587
Wood	54,564	28%	15,278	113	$16,243,509
TOTAL	3,679,965	25%	940,555	7,357	$1,000,000,000

cigarette smoking. This ranged from a low of 6 in Menominee County to a high of 1,532 in Milwaukee County.

Hospital expenses accounted for most of $1 billion smoking costs in Wisconsin, followed by ambulatory physician care, nursing home care, prescription drugs, and home health care (Table 2).[1] County expenses in 1993 ranged from $560,669 in Menominee County to $206,393,591 in Milwaukee County.

Discussion

As these data show, cigarette smoking in Wisconsin continues to cause many deaths (7,357), and accounted for $1 billion in medical care expenditures in 1993. Using these national and state estimates, the health and economic burden of smoking is apparent for each of Wisconsin's 72 counties.

Our methodology has a number of limitations. First, our estimates were based on national and state data and applied to counties on the basis of population. Data derived directly from the counties would be more accurate, particularly in those counties with significant populations of groups with higher smoking prevalence. For example, previous surveys in Milwaukee County (eg, the 1989 Milwaukee Planning Council health status survey) have demonstrated higher smoking rates in urban residents than suburban residents.

Second, the population-attributable risk estimates were based on state smoking rates, and were not adjusted for local smoking rates. The effect of such an adjustment would likely be minimal, however, since the population-attributable risk (PAR) depends upon both the prevalence of smoking (P) and the relative risk (RR) of disease [PAR = P(RR-1)/(1+P(RR-1)]. Further, the smoking rates most relevant for these calculations would be those from 20 years ago; these rates are unavailable.

Third, these data underestimate the health and economic consequences of cigarette smoking, as they do not include all direct medical costs attributable to smoking (eg, burn care from cigarette-smoking-related fires, perinatal care for low birth weight infants of mothers who smoke, and costs associated with diseases caused by exposure to environmental tobacco smoke).[1] Further, the indirect costs, which

Table 2.--Medical Costs in Wisconsin, by category, attributed to smoking, 1993.

Category	State total
Hospital	$ 538,000,000
Physician	$ 310,000,000
Nursing home	$ 98,000,000
Prescription drugs	$ 36,000,000
Home health care	$ 18,000,000
Total	$1,000,000,000

were nationally estimated at more than $40 billion in 1990, were not included in these estimates. Examples of indirect costs attributable to cigarette smoking include days of work lost and decreased productivity due to smoking-related morbidity and premature mortality.

The data presented in this report serve as a useful starting point for estimating the health and economic impact of cigarette smoking on Wisconsin counties, and provide initial data for monitoring trends. In addition, the methods used here may be helpful to other states and communities attempting to estimate the local effect of cigarette smoking. (See accompanying article, page 578.) The health and economic burden of cigarette smoking on every community in Wisconsin is compelling. This information is critical when setting priorities for community based prevention programs.

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5. Center for Health Statistics. Vital Statistics 1992. Wisconsin Dept. Health Soc Services, Dept Health, Center for Health Statistics 1992. ❖

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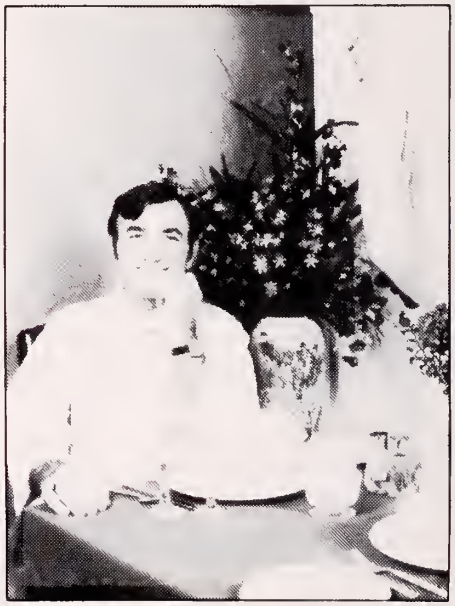

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The Feb 23, 1994, issue of *JAMA* published the following list of names of magazines that carry no tobacco advertisements. If anyone's favorite tobacco-free magazines have been inadvertently omitted from this list, *JAMA* invites them to write so they may be included next year.

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Air & Space 370 L'Enfant Promenade SW, Washington, DC 20024
Alaska Magazine 808 E St., Achorage, AK 99501
American Baby 475 Park Ave., New York, NY 10016-6999
American Health 28 W. 23rd St., New York, NY 10010
American Heritage 60 Fifth Ave., New York, NY 10011
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The American Philatelist PO Box 8000, State College, PA 16803
American Square Dance PO Box 488, Huron, OH 44839
American Woman PO Box 463, Mount Morris, IL 61054
American Woodworker PO Box 7579, Red Oak, IA 51591
Americas 1889 St., Nw, Washington, DC 20006
Animal Kingdom 185th St & Southern Blvd., Bronx, NY 10460
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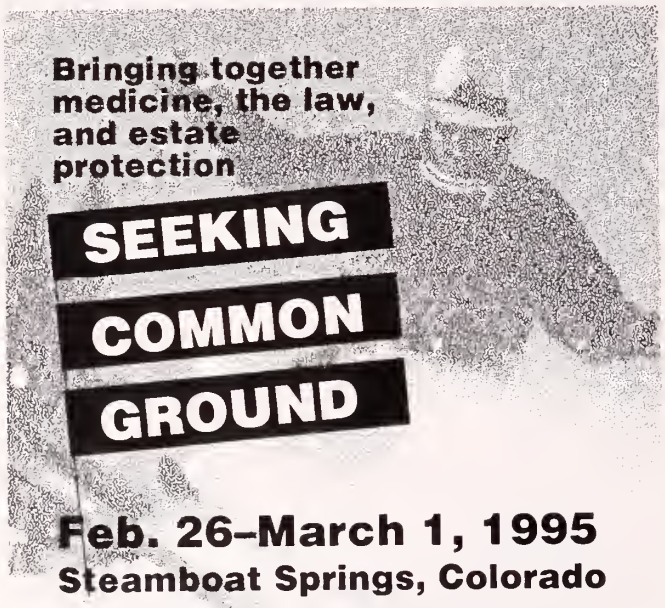

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Flower & Gardening Magazine PO Box 7503 Red Oak, IA 51591
Folk Art Museum of American Folk Art, 61 W 62nd St., New York, NY 10023
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Hadassah Magazine 50 W. 58th St., New York, NY 10019
Harvard Business Review Teele Hall, Boston, MA 02163
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CDC report on teen smoking

The Centers for Disease Control and Prevention recently released a report that says there is a powerful link between smoking among adolescents and their difficulty in quitting due to addiction.

The report, based on the CDC's 1993 Teenage Attitudes and Practices Survey among persons aged 10 through 22 years, focuses on the reasons young people use tobacco, both cigarettes and smokeless, or "spit," tobacco, and the symptoms of nicotine withdrawal.

The survey found that among students who were high school seniors during 1976-1986, 44% of daily smokers believed that in 5 years they would not be smoking; however, follow-up with these smokers 5 to 6 years later found that 73% remained daily smokers. In an editorial note, the report says: "This finding suggests that many of these persons could not overcome the social, psychological and chemical influences that maintain or advance smoking once it becomes established and indicates that many adolescents do not understand the personal risks of smoking, including nicotine addiction."

The report cites a 1992 Gallup survey where two thirds of adolescent smokers reported that they wanted to quit smoking and where 70% indicated that they would not have started smoking if they could choose again. The report suggests strategies to help keep young people from starting to smoke, including prohibition of sales to minors and the "reduction of advertising and promotion practices that stimulate demand."

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PROSERVICES

The daily burden of smoking in an average Wisconsin community

Richard A. Yoast, PhD, Madison

An accompanying article in this *WMJ* (see page 569) reviews the burden of cigarettes in Wisconsin by county. This article will use that data to illustrate how smoking impacts a typical county in Wisconsin.

Background

National and state estimates of smoking rates, their health effects and economic burdens typically receive a great deal of media attention. In 1992, an estimated 48 million (26.5%)adults were current smokers, an increase of 0.9% over 1991, indicating a virtual halt in the decline of national smoking prevalence since 1990.[1] The human costs of this level of smoking have been well documented in premature mortality, increased morbidity, patient and family suffering when cancer and emphysema strike, and the tremendous burdens of smoking related health care, insurance and employer costs.[2] The economic burden attributable to smoking has also been well studied and made known; in Wisconsin the costs are estimated to exceed $1 billion (1992).[3] Nationally, the Office of Technology Assessment estimated that in 1990 the total financial cost of smoking was $68 billion or $2.59 per pack of cigarettes, $1,078 per smoker and $272 per capita.[4]

Such national and state figures are impressive, even staggering. But they are difficult for many citizens to comprehend or personally relate to. Conversely, the personal costs of smoking are persuasive and far easier to comprehend but they ignore the relationship to local impacts which helps move citizens from individual smoking cessation to collective community action. In this light, I will show how localized data, relevant to a particular community (eg, an average Wisconsin county), can be presented to illustrate how smoking affects citizens in that community and how that data can be used to argue for local tobacco control policies.

Methodology

The average county population size in Wisconsin is 67,941. (Derived by dividing the total state population of 4,891,769, [US Bureau of Census, 1990] by 72 counties, or 67,941.) Counties, of course, vary greatly in size, population characteristics, urban density, and smoking rates. With greater specificity of data, a more accurate picture could be derived for any given county. But for the purposes of illustration we will use data from a county close in size to the average--Jefferson County (est. population 67,783, 1992).

Jefferson County

An examination of the burdens of smoking, even in a relatively small population, indicates a sizeable community burden, perhaps larger than many would expect offhand. The figures from larger counties begin to reach figures that again become hard for individuals to relate to. A look at Jefferson County's data[5] reveals the following: the estimated total number of packs of cigarettes smoked yearly by its adults total 6,828,269. This results in estimated smoking-related health care costs for the county in 1994 of $12,826,549-- or $1,063.20 per smoker per year.

Reduction of this data to a daily burden for Jefferson County offers information that is likely to be meaningful for the average county resident. For example, in Jefferson County adults smoke an estimated 18,708 packs per day. In human cost this results in many infants born annually to mothers who smoke, with increased risk of low birth weight, infant mortality and childhood illness.

The burden of smoking-related illnesses and deaths is rarely viewed as a major public health crisis. The deaths and suffering from smoking are usually experienced privately by the victim, family and close friends. These personal crises are seldom reported in the mass media. In Jefferson County, however, 92 people prematurely die every year from these illnesses. This accounts for an estimated 17.5% of all deaths and over 1,000 years of potential life lost in this county; the state total of potential years of potential life lost in 1990 was 86,345.[6] Assuming close relationships with only 10 other people, these unpublicized personal illness and death-related traumas will directly affect 9,200 Jefferson County residents--or 14% of the total population every year.

If such an event were compacted into a few days, it is likely the county would declare a public emergency. By comparison, nationally and in Wisconsin, deaths from smoking surpass those from alcohol, cocaine,

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The public health column is not reviewed by the *WMJ* editorial board. Dr Yoast, a political scientist, is the director of the ASSIST Project, Bureau of Public Health, Wisconsin Division of Health. Reprint requests to: Richard Yoast, PhD, Wisconsin Division of Health, 1414 E Washington Avenue, Room 240, Madison, WI, 53703-3041. Copyright 1994 by the State Medical Society of Wisconsin.

crack, heroin, homicide, suicide, car accidents, fire, and AIDS.[7]

The daily health care cost from smoking in Jefferson County is $35,141. Health care costs, however, are not distributed equally across the population. Public and private third party payments such as medical assistance, employer health insurance, and individual payments assume the costs for those who can pay less or because smoking-related illness cost far more. Thus, these costs are distributed to a broad population of taxpayers and health care cost payers.

The real cost of smoking, however, originates not in health care but in the use of the product, cigarettes. In Jefferson County, every pack of cigarettes smoked by adults results in a health care expenditure of $1.88 to smokers and non-smokers alike.

A profile of smoking in Jefferson County, Wis. (pop. 67,783 - 1992).[5]

	Adult smokers (age 18+)	Youth smokers (age 11-17)
Per cent of same-age population	24%	23%
Number of smokers	12,064	1,592
Packs smoked/person/year	566	133
Packs smoked/county/year	6,828,269	208,503
Packs smoked/county/day	18,708	571
Smoking-related deaths	92	
Births to mothers who smoke (1990-1992)	642	
Smoking-related health care costs/ year	$12,826,549	
Smoking-related health care costs/ day	$ 35,141	

Sales to minors

Approximately "75 % of current smokers became addicted to tobacco by age 18 [and]... About half of the tobacco industry's profits, $3.35 billion derives from sales to smokers who become addicted as children."[8] In Jefferson County, this means an estimated 12,064 adult smokers became addicted before they were of legal age to smoke cigarettes. About 75% of them are likely to have come from families in which one or both parents smoked.[7] This long term addiction, starting in childhood, leads to estimated adult health care costs of $9,619,912 (75% of the total smoking related costs), or a daily estimated cost in Jefferson County of $26,356. Smoking by and sales to minor is a costly issue for this county.

The Centers for Disease Control 1993 Teenage Attitudes and Practices Survey (TAPS-II)[9] found that cigarette brand preferences among current smokers aged 12 through 18 years in the Midwest were 61.6% for Marlboro, 15% Camel, and 11.6% Newport. These were also the three most heavily advertised brands. When applied to Jefferson County, youths ages 11 through 17 annually smoke an estimated 128,438 packs of Marlboro, 31,275 packs of Camel, and 24,186 packs of Newport.

Virtually all of these are obtained and smoked illegally. Youth generally obtain most of their cigarettes in single packs through sales and theft made easy by self-service stands in retail outlets, permissive illicit sales by adults to minors and from vending machines.[8] Assuming that most such procurement occurs between the hours of 7 AM and 11 PM (16 hours), during every daytime hour (n=5840) in Jefferson County there are more than 35 illegal tobacco transactions involving minors with the assistance of a great many adults. It is certainly fair for each parent in the county to ask why youth are encouraged and willing to obtain these products and why, andwhich, adults are willing to contribute to such illicit behaviors; and what is the community's public sector doing to help stop this?

Discussion

The data presented indicates that even reduced to daily, local levels, the effects of smoking on an average Wisconsin community is considerable. Given the relative ease with which this local data can be obtained its use can provide a strong advocacy tool.

For example, such information is useful for contradicting the broad, often misleading, and inaccurate generalizations made by tobacco companies about smoking by revealing its effect on all adults, and especially adults concerned about smoking by minors. We can, with a fair degree of specificity, attach the role of individual companies in this (eg, R J Reynolds produces Camels, Philip Morris produces Marlboro).

We can also identify for each taxpayer and payer of health care costs what their local burdens are. Because these burdens are distributed unequally across the community an appeal can be made for action to several groups likely to be most concerned such as parents of minors, pediatricians, school staff, public officials, and health care providers and insurers. Other sectors, law enforcement and public health, also face considerable burdens when smoking related behaviors and risk factors are included (eg, smoking among minors is closely correlated with illicit drug use, other risk-taking behaviors, and school failure).[7] In addition, we can point to which tobacco companies especially profit from smoking by minors.

Continued on next page

Continued from preceding page

Policy linkages

A final step should be to link the data regarding local smoking-related burdens to specific public and private policies which would remediate or remove these burdens. A brief look at major tobacco control policy strategies indicates a number of such data-policy linkages.

1. A common policy strategy is to increase the cost of smoking through taxation and fees so as to increase an individual's motivation to quit or not start smoking. Youth are especially sensitive to such pricing strategies. Citing health care costs, death rates, births to women who smoke, and individual smoking-related burdens, an argument can be made that the public and private costs of smoking are enormous. When connected with taxation as a means to discourage smoking and to cover some of the economic burdens from smoking, this data can provide incentives for community members to support state and national efforts in this area.
2. Another important policy strategy to prevent smoking by youth is to restrict the number of cigarette advertising messages targeting them: In this case, one can cite local youth smoking data, especially specifying brands appealing to youth, and point to the numerous billboards, convenience and other retail store promotions which visibly abound in every community. This evidence can be used to argue for local restrictions on billboard advertising (especially near schools and on public property). It can also be used to encourage private agencies and groups to refuse tobacco industry advertising and sponsorship (eg, for events youth attend), to fund public counter-advertising efforts, and to persuade merchants to reduce tobacco advertising aimed at youth.
3. Another key policy strategy to prevent smoking by youth is to reduce youth access to tobacco products. Again, all of the youth-related data is relevant here. It can be used as evidence of lax public and private enforcement of laws prohibiting sales to minors and to call for local ordinances, state laws, and enforcement measures to rectify this situation. Local compliance checks on sales to minors can even more clearly illustrate the problem. Such data can also be used to indicate the need for renewed preventive education activities and services to help parents of minors quit smoking.
4. Finally, the strategy of expanding clean indoor air coverage is necessary to induce smokers to quit smoking and to protect non-smokers from environmental tobacco smoke (ETS). The number of adults and youth who continue to smoke can indicate that major smoking related problems and the dangers of ETS are still present in our society. This data also indicates that a vast majority of the population does not smoke and is likely to support measures to protect them from ETS. Smoking related health care costs can be used to show the economic effects of smoking on the entire community. Specific policies which can be identified for local action here include, public and private prohibitions on smoking in work sites (especially where minors are present), facilities open to the public and in schools not already covered by state laws banning smoking.

In summary, the use of local data, tied to policy initiatives, can move public and private decision makers towards a reassessment of the burdens of smoking in our community. This policy linked data can then also be used as tools to motivate policy makers toward action to reduce the levels of smoking in the community.

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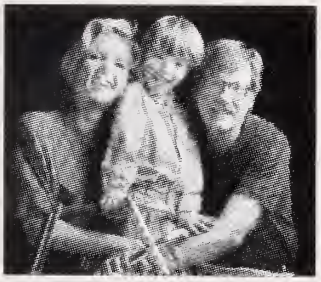

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Attitudes of the Wisconsin State Legislature toward tobacco control policies

Robert Gifford and Marge S. Brindley, MS, Milwaukee

During the summer of 1994, the American Lung Association of Wisconsin (ALAW) conducted a survey of Wisconsin State legislators. At that time, a new version of Senate Bill 383 was being drafted. This bill would have extended the power of the existing Clean Indoor Air Act to cover shopping malls, common areas of multi-family dwellings, and other public areas. Another key issue in tobacco control was the removal of a clause in state statutes that preempts any local ordinances restricting sales or youth access to tobacco products which are not in strict conformity to state law. Preemption is a strategy used nationally by the tobacco industry to prevent strong local ordinances which are often broader and stronger than state laws. The new bill, however, made no attempt to tackle the preemption of local youth access to tobacco products ordinances.

In addition, a legal challenge to preemption language was being conducted in Fond du Lac. Convenience stores, bolstered with money from oil and tobacco companies, were challenging a local ordinance which required individual packages of cigarettes to be sold from behind the counter by a vendor. The outcome of the lawsuit was not yet known, but those aware of the proceedings tended to regard the suit as a watershed test of Wisconsin's existing preemption laws. (Editor's note: In late October, a Fond du Lac County circuit judge ruled invalid a local ordinance toughening penalties on under-age tobacco buyers and the retailers who sell the products to them.)

At the federal level, the 1991 Synar amendment to the Alcohol and Drug Abuse Block Grant to states was being enforced by the Department of Health and Human Services (DHHS). This amendment requires that states take strong measures to reduce sales of tobacco products to minors and to be able to prove actual reductions in youth cigarette purchases rates (to achieve a goal of no more than 20% noncompliance to laws prohibiting sales to minors), or lose progressively larger portions of the block grant to states not in compliance. In Wisconsin, sales to minors compliance checks by local Tobacco Free Wisconsin coalitions have demonstrated 40% to 90% non-compliance with state laws. Wisconsin's Department of Health and Social Services (DHSS), which administers the block grant, had arranged to secure the full measure of block grant money during fiscal year 1994, but had no guarantees concerning fiscal year 1995.

Also at the federal level, debate continued regarding the level of a national excise tax on cigarettes. Though it was widely speculated that any national tax, if increased, would be in the range of 30 cents to 50 cents, many legislators adopted a wait-and-see attitude to the issue.

Purpose

This report is a summary of the responses obtained from Wisconsin state legislators (hereafter referred to as "subjects") to a survey sent to their Madison offices. The survey was intended to gauge their initial positions on ALAW issues before debate began in the winter of 1994-1995. Subjects were informed that their names would not be directly associated with their responses if the results were presented to the media. Similarly, subjects were guaranteed that no candidate endorsements would be made as a result of their responses.

Methodology

A survey was constructed which probed the subjects' views on three main areas of ALAW policy. A copy of the survey form is available from the authors. The three main areas were: cigarette excise tax, the Synar amendment, and clean indoor air. A brief synopsis of each topic was provided as background. The survey was sent to the subjects' offices two weeks in advance of the due date. Those subjects who did not return the survey were contacted and sent second copies of the survey if they so desired. The researcher also spoke to several of the subjects in person. In these cases, special care was made not to either take the responses out of context or to characterize the responses as overly favorable or negative.

Results

Of the 132 legislators contacted, 52 (31%) responded to the survey (40/99 (40%) from the Assembly and

Gifford was an intern and Brindley is the director of programs with the American Lung Association of Wisconsin.
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12/33 (36%) from the Senate). The results of each question is given first for the Assembly (A:), then for the Senate (S:);

"Would you consider supporting a cigarette tax as a way to discourage smoking among minors?"
Assembly (n=38) Senate (n=11)
Yes= 76% No= 24% Yes= 91% No= 9%
Comments. Some respondents felt that the language "to discourage smoking among minors" was inappropriate. Such was not their goal. Indeed, many subjects recognized the inefficiency of using the cigarette tax as a source of funding because the tax would reduce demand for the product and might therefore reduce tax revenues. (The experience in other states has been that a substantial tax increase, eg, of 25 cents or more, more than offsets the number of smokers who quit. In addition, when people quit due to tax increases savings are realized in other areas such as health care.)

"Revenue generated by a cigarette tax should be applied to: (check all that apply)"
Assembly (n=40)
Property tax relief= 15%
State general revenue= 12%
Health care programs= 73%
Health care for uninsured= 48%
No tax= 18%
Senate (n=11)
Property tax relief= 27%%
State general revenue= 36%
Health care programs= 73%
Health care for uninsured= 45%
No tax= 9%

"How much of an increase in the tax on cigarettes would you support? (in dollars per pack)"
Assembly (n=27) (not including "no-tax" responses)
Mean value= $0.74
Mode value= $1.00
Median value= $0.50 50% of subjects would vote for $0.50 tax or greater.
Senate (n=5) (not including "no-tax" responses)
Mean value= $0.60
Mode value= $0.50
Median value= $0.50 50% of subjects would vote for $0.50 tax or greater."

How high of a priority is compliance with Synar?"
Assembly (n=27)
"High priority" or "Non-compliance isn't worth losing grant money" = 97%
All others= 3%
Senate (n=9)
"High" or "...isn't worth losing grant money" = 90%
All others= 10%

"Do you favor compliance checks of stores which sell tobacco?"
Assembly (n=38)
Yes= 95% No= 5%
Senate (n=10)
Yes= 90% No= 10%

"If you answered yes to #5, how frequently should these checks be conducted?"
Assembly (n=17)
1 time/year= 35%
2 times/year= 24%
3 times/year= 41%
50% would vote for "two times per year" or more often.
Senate (n=6)
2 times/year= 91%
3 times/year= 8%
50% would vote for "two times per year" or more often.

"What types of penalties do you favor for non-compliance? (check all that apply)"
Assembly (n=32)
Current fines= 22%
Stronger fines= 28%
Fines on the minors= 56%
Fines on the clerk= 22%
License suspension= 56%
Senate (n=12)
Current fines= 17%
Stronger fines= 33%
Fines on the minors= 50%
Fines on the clerk= 33%
License suspension= 67%

"Do you favor an increase in the licensing fee for tobacco vendors? (The current fee is $5)"
Assembly (n=34)
Yes= 56% No= 44%
Senate (n=7)
Yes= 43% No= 57% (among respondents)

"Would you support contracting a private agency to conduct compliance checks if it were more cost-effective than state-administered checks?"
Assembly (n=33)
Yes= 82% No= 18%
Senate (n=7)
Yes= 82% No= 18%

"Would you support a ban on cigarette vending machines?"
Assembly (n=30)
Yes= 50% No= 50%
Senate (n=8)
Yes= 50% No= 50%

"Do you support restrictions of, or bans on, smoking in: shopping malls? private schools and colleges? small restaurants? common areas of multi-family dwellings?
Comment. This question spawned a wide variety of answers. This study is unable to identify anything more specific than a general trend in favor of the measures.

"Do you support allowing local governments to adopt legislation stronger than that of the state government?"
Assembly (n=38)
Yes= 82% No= 18%
Senate (n=11)
Yes= 72% No= 27% (among respondents)

Analysis
The results of this survey suggest that Wisconsin legislators are at least somewhat amenable to those positions taken by the ALAW and other tobacco control advocates. It is important to note, however, that the sample population may not be representative of the entire legislature. Though the 40% sample size is adequate, the respondents may be self-selected to answer this survey based on their views. Thus, any generalizations made from this data should be tempered by the fact that the responses are probably biased towards the ALAW position.

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It seems that a modest cigarette tax is generally supported by the legislature. With both houses reporting massive support for a tax, it is unlikely that an increase would be ruled out of hand. This data also suggests that a tax increase of 50 cents would be supported in both houses, though the margin of success is narrow in both cases. Support rises quickly as the amount of the tax decreases. For example, nearly 80% of those in support of a tax would vote for a 25-cent increase. Whatever tax is passed, it will probably be applied to health programs in one form or another. Some support was found for applying revenues generated by the tax to anti-smoking education programs. Though the legislature is committed to property tax reduction, little support was found for applying tax revenue to property tax relief.

The federal Synar amendment remains an under-recognized issue in both houses. Numerous legislators and their aides confessed virtual ignorance of the issue. One reason for the low response rate to Synar questions was this ignorance. Even when the researcher had two-way conversations with the legislators, they were unwilling to commit without more knowledge. Many legislators are also unwilling to take interest in the issue because DHSS will decide most of the policy. This survey suggests that if the Wisconsin DHSS is to obtain any requested funding for Synar enforcement in the fiscal year 1995 appropriations process,more legislators must be educated on the issue.

A surprising amount of support was found for the proposal to ban cigarette vending machines. Both houses split evenly on the issue. Little of the support was vehement; debate on the issue may very easily sway supporters away from the ban, especially if the vending machine ban can be sacrificed for more pressing legislation.

The Clean Indoor Air Act amendments seem to be generally supported, especially in light of the success they enjoyed last session. Surprisingly, removal of preemption of stronger local youth access ordinances enjoys general support as well despite its failure during the last legislative session. This may be due to a strong sense in the legislature that counties have as much autonomy as possible. A weighty 82% of representatives and 72% of senators support a measure to strike preemption. Though only a fraction of the total legislature responded to the survey, preemption is not as closed an issue as the failure of SB 383 may suggest.❖

Tobacco acquisition practices of adolescents in two Wisconsin communities

Joseph Cismoski, MPH, and Marian Sheridan, RN, Fond du Lac

More than 2,000 students in two Wisconsin communities were surveyed on their tobacco use and acquisition habits. The results indicate a defined pattern of acquisition across the three grade levels surveyed. Eighth grade tobacco users buy or "bum" tobacco from friends but also use a wide variety of methods and sources. Tenth and 12th grade tobacco users primarily purchase tobacco from businesses. About one third of 8th grade tobacco users regularly buy from vending machines and almost half of the 8th and 10th grade tobacco users in one of the communities have shoplifted tobacco during the past year, with 12% most often obtaining tobacco in this manner. These patterns of acquisition may have a contributory effect on the high prevalence of adolescent tobacco use reported in both communities. The results argue for meaningful enforcement of laws prohibiting tobacco sales to minors and the elimination of self-service sales of tobacco products. *Wis Med J.1994;93(11):585-591.*

Tobacco use is associated with an array of long-term adverse health consequences, but adolescent tobacco users also exhibit a number of acute responses, including an increase in coughing and phlegm production, impaired lung function, and compromised physical fitness in levels of performance and endurance. The onset of tobacco use in the majority of adolescents occurs decades before the morbidity and mortality associated with adult tobacco users. Current epidemiological research on tobacco use in adolescents demonstrates a past 30 day prevalence of cigarette use ranging from 17% to 32% and smokeless tobacco use ranging from 7% to 11%.[1,2]

The high prevalence of tobacco use in youths may be attributed, in part, to the proven existence of easily accessible tobacco products.[3,4] Ease of purchase from retail outlets has been substantiated by compliance check studies but there are few data that present a profile of the methods and sources that teenagers use to obtain tobacco at different ages. This report uses responses from more than 2,000 8th, 10th, and 12th grade students from two Wisconsin communities to examine their self-reported tobacco acquisition practices.

Cismoski is with the Fond du Lac School District. Sheridan is with the Fond du Lac County Public Health Nursing Department. Reprint requests to: Joseph Cismoski, Fond du Lac School District, 72 S Portland St, Fond du Lac, WI 54935. Copyright 1994 by the State Medical Society of Wisconsin.

Methods

In January 1994, the Michigan Alcohol and Other Drugs School Survey was administered to the 8th, 10th and 12th grade populations of the public school district in Fond du Lac, Wis. An addendum of questions which included items specifically addressing tobacco use habits, was included with each survey booklet. The anonymous survey was administered following a proven procedure, by a research associate from Western Michigan University and the authors of this article to student groups ranging from 50 to 150 without teachers present. Passive consent was obtained prior to the survey and students were discretely monitored to discourage discussion and collaboration.

In February, a survey made up of specific tobacco and alcohol questions from the Michigan survey and Fond du Lac addendum was administered in much the same fashion to same grade populations in the Manitowoc, Wis, public school district. Completed answer forms from both districts were sight-screened for response sets and other erratic response patterns.

Fond du Lac and Manitowoc are east-central Wisconsin communities located approximately 60 miles apart. They match up closely in the following demographic categories: population; median household and family income, including numbers who earn below $15,000 per year; numbers below the poverty level (Fond du Lac, 3489; Manitowoc, 3344); educational attainment for persons 25 years or older, including the number of people with less than a high school diploma (Fond du Lac, 5281; Manitowoc, 5641); and percentage of high school graduates. Both Fond du Lac and Manitowoc are racially homogeneous (Fond du Lac, 98% white; Manitowoc, 96% white). The largest minority population in Fond du Lac is Hispanic (1.5%) and in Manitowoc, Asian (2.5%), according to the Wisconsin Department of Administration.

Results

A total of 1,240 students were surveyed in Fond du Lac with response rates of 88%, 70%, and 62% for grades 8, 10, and 12, respectively. Response rates for the 928 students from the same grade levels in Manitowoc were 87%, 76%, and 68%.

The prevalence across the three grade levels, for past 30-day cigarette use in both Fond du Lac and

Manitowoc was about 35%. No such congruence was reported for past 30-day smokeless tobacco use. The prevalence in Fond du Lac (15%) was almost twice that in Manitowoc (8%) (Table 1).

Almost 50% of Fond du Lac 8th and 10th grade tobacco users reported shoplifting tobacco within the past year. This figure was almost 40% for the same grades in Manitowoc. Percentages fall to about half of these in each of the communities for respondents in grade 12 (Table 2). Shoplifting was reported as the most often used method of obtaining tobacco by 12% of grades 8 and 10 tobacco users in Fond du Lac and 6% by their Manitowoc counterparts. In contrast, shoplifting was identified as a typical way of procuring tobacco by roughly 2% of 12th grade students from both cities. (Table 3)

Table 2 also shows that from half to two thirds of current tobacco users in the 8th and 10th grade in both cities reported using vending machines at least once in the past year. The prevalence drops for 12th grade to 34% in Fond du Lac and 43% in Manitowoc. Regular use of vending machines is greatest for tobacco users in 8th grade (23%, Fond du Lac; 39%, Manitowoc) and tapers off to 4% in Fond du Lac and 6% in Manitowoc 12th grade students (Table 3).

Free samples as a source of tobacco were used by about 50% fewer students than vending machines. About one third of tobacco users in Fond du Lac and 20% to one quarter in Manitowoc reported receiving free samples at least once during the past year. (Table 2) The use of free samples was roughly equivalent at all grade levels.

These data reveal considerable similarities in the acquisition habits of current tobacco users within each of the grade levels and some very notable differences between the grade levels. In general, 8th grade students from Manitowoc and Fond du Lac show a preference for "bumming" (defined as "persuading others to give it [tobacco product] to me" on the questionnaire) and buying from friends as ways to obtain tobacco products. A slightly greater percentage of Manitowoc students supplement these primary methods by buying from businesses. Eighth grade tobacco users from Fond du Lac on the other hand, show a greater propensity to shoplift and to buy or "bum" from adults other than parents in addition to from friends.

Interestingly, "other ways" was reported by a sizable fraction, about 25%, of students in both communities. There were no examples of "other ways" given on the questionnaire. Some participants, however, anecdotally indicated a misunderstanding of that response leading us to believe that one of the three alternate answers listed in Table 3 would have more accurately represented their behavior. Tobacco using students in 8th grade from Manitowoc report a slight preference for vending machines as sources of purchased tobacco. Fond du Lac students clearly prefer buying from salesclerks. When tobacco users from either community elect to buy from businesses that sell over the counter, almost one third indicated that they have someone else buy the tobacco for them.

The rather diversified methods of tobacco acquisition reported by the youngest tobacco users surveyed is contrasted by a more discriminate pattern in 10th grade students. Table 3 reveals that almost two thirds of current tobacco users from Manitowoc, and slightly less from Fond du Lac, usually purchase their tobacco from businesses. Over-the-counter purchases are clearly favored. There seems to be no distinct preference when buying over-the-counter. Self-service, asking the clerk, and asking someone else to buy are reported by about the same percentages. An exception would be the preference by Manitowoc students to serve themselves.

In 12th grade, the manner in which tobacco is usually acquired is a settled matter. Three quarters of the survey participants report buying tobacco products as the most often employed method of obtaining them. Two thirds of seniors usually purchase from businesses with more than 90% buying over-the-counter. Unlike students in the lower grades there is a greater preference for asking clerks for tobacco, though, students from Manitowoc almost equally preferred self-service.

The most often used types of re-

Table 1.--Past 30-Day tobbaco use by grade(in percentages).

	8th			10th			12th		
	FdL*	Man	Natl+	FdL	Man	Natl	FdL	Man	Natl
Cigarettes	30.8	27.0	16.7	34 3	41.7	24.7	38.4	34.4	29.9
Smokeless	10.7	6.1	6.6	18.5	14.6	10.7	14.8	3.6	10.7

*FdL = Fond du Lac, Man = Manitowoc.
n for 8th grade:FdL=508; Man=327; n for 10th grade:FdL=374; Man=320; n for 12th grade:FdL=319; Man=249.
+National percentages are for 1993.
Source: Johnston L, O'Malley P, Bachman L. National Survey Results on Drug Use from The Monitoring the Future Study, 1975-1993.

tail outlets, for tobacco purchases, were the same for all three grade levels in both communities. Gas stations and convenience stores were used 2 to 1 over the next preferred outlet. Food stores are distinctly favored as a third source by older tobacco users, though less so in Manitowoc. Bowling alleys are also popular locations for purchasing tobacco, especially by 8th and 10th grade students.

Table 2.—Vending machines, free samples, and shoplifting as means of obtaining tobacco products*at least once in the past year by current tobacco users (in percentages).†

	8th[‖]		10th[§]		12th[‖‖]	
	FdL[¶]	Man	FdL	Man	FdL	Man
Vending machine	54.7	59.3	66.0	69.8	33.9	42.5
Shoplifting	46. 6	39.5	45.8	37.9	28.0	20.0
Free samples	34.8	20.9	35.4	25.6	28.0	17.5

*"tobacco products" and "tobacco" were defined as cigarettes, smokeless tobacco or both
†"current tobacco user" was defined as cigarette smoker, smokeless tobacco user, or both, at the time of the survey
‖Man: n=75; FdL: n = 146
§Man: n=122: FdL: n = 136
‖‖Man: n='71; FdL: n= 118
¶FdL = Fond du Lac, Man = Manitowoc

Discussion

One of the more surprising revelations from the survey is the reported shoplifting by tobacco users at 8th and 10th grade levels. The percentages of students from Fond du Lac and Manitowoc reporting shoplifting tobacco products potentially represent a significant amount of tobacco obtained without paying for it.

There is a paucity of data on teenagers shoplifting tobacco products despite the fact that cigarettes have been identified in at least one survey of retailers, as the most shoplifted item.[5] Self-report of shoplifting tobacco products ranges from 5% of students in grades 7 through 12 in Georgia to about 44% of 9th grade daily smokers in Erie, Penn.[6,7] The data presented here reveal that the practice falls off precipitously as students move into 12th grade. Younger teens may shoplift early in their use of tobacco to augment other methods of tobacco acquisition. As they get older, shoplifting becomes less attractive perhaps because of the combination of an increase in disposable income along with an increase in the ease of purchase. Buying may also be perceived as less risky (with no risk involved for those over 18) than shoplifting. Quality may also take precedence over quantity as it has been demonstrated that teens are brand conscious.[8] Brand preference may also play a part as it may be more difficult to shoplift a specific desirable brand.

That so many, especially younger teens, engage in shoplifting suggests that it is easily done. Self-service displays make tobacco products accessible to everyone and have been associated with successful purchases by minors.[4] Such displays also facilitate shoplifting. The difference in the rate of shoplifting reported between Fond du Lac and Manitowoc may be due to differences in the numbers, kinds, and locations of self-service displays and variations in the monitoring of those displays. The results concerning vending machines are consistent with those reported elsewhere.[9,10] Though using a vending machine at least once in the past year was reported by a greater percentage of 10th grade students, 8th grade tobacco users are more likely to use them as usual sources of tobacco. Regular use of vending machines diminishes with increasing age.

Demographic similarities between Fond du Lac and Manitowoc likely account for the nearly identical reporting of past 30-day smoking by the student population surveyed. These higher reported percentages than national samples such as those from the annual high school survey by the National Institute on Drug Abuse (Table 1) and the Centers for Disease Control and Prevention's Youth Risk Behavior Survey are more difficult to explain.[1,2] One reason for this may be that the samples for the national surveys are apt to be more heterogeneous than the populations of Fond du Lac and Manitowoc, both of which seem to have considerable subsets of their populations with characteristics that positively correlate with the use of tobacco.

More puzzling is the marked difference in smokeless tobacco use between Fond du Lac and Manitowoc. Demographic variables positively associated with smokeless tobacco use in youths are lower parental education, blue collar parental occupation and rural lifestyle.[11] These would controlled for by similarities between the communities. The student populations are also very similar on the important behavioral variable of academic achievement.

Environmental and personal variables are also important in tobacco use, including the use of smokeless tobacco. Perceived availability is one such environmental variable and perceived harmfulness is one such personal variable. Substantially greater percentages of Fond du Lac students reported tobacco to be fairly easy or easy to obtain and substantially smaller

Table 3.—Usual methods of obtaining tobacco products by current tobacco users* (in percentages).

	8th†		10th††		12th§	
	FdL‖	Man	FdL	Man	FdL	Man
Method						
"bumming"	31.4	30.6	19.9	15.1	15.5	13.7
buying	28.8	37.6	57.4	64.3	75.0	76.7
shoplifting	12.4	5.9	12.1	5.6	1.7	2.7
other ways	27.5	25.9	10.6	15.1	7.8	6.8
Source						
parents/guardians	15.9	13.6	17.7	9.5	5.1	5.4
other adults	20.5	11.1	7.1	11.9	9.4	5.5
brother/sisters	9.9	7.4	7.8	8.7	2.6	2.7
friends	41.1	48.1	27.7	18.3	23.1	20.3
businesses	12.6	19:8	39.7	51.6	59.8	66.2
Type of purchase						
vending machines	22.9	38.9	13.0	26.4	3.5	5.9
over-the-counter purchase	47.1	29.2	72.5	66.1	93.0	91.2
from someone "on the street"	30.0	31.9	14.5	7.4	3.5	2.9
Over-the-counter purchase						
serve myself	20.9	12.7	33.3	40.3	24.6	33.2
ask the clerk	25.0	17.7	29.1	28.2	55.1	38.9
ask someone else to buy for me	30.4	32.9	27.7	23.4	17.8	19.4
"I never buy over-the-counter."	23.6	36.7	9.9	8.1	2.5	8.3

Of 12th grade participants, 44% (Man) and 42% (FdL) reported their age to be 18 years or older, the legal purchasing age for tobacco in Wisconsin. This should be considered when looking at 12th grade responses.
*"current tobacco user" is here defined as cigarette smoker, smokeless tobacco user, or both, at the time of the survey
†Man: n's range from 72 to 85; FdL: n=161
††Man: n's range from 124 to 126; FdL: n=144
§Man: n's range from 72 to 74; FdL: n=118
‖FdL = Fond du Lac, Man = Manitowoc

percentages reported smokeless tobacco to pose a great risk.[12] Perceived availability has been shown to be an accurate reflection of actual availability and lack of knowledge on the health effects of smokeless tobacco have been shown to positively correlate with use.[4-11] These may at least partially explain the increased rates of use of smokeless tobacco in Fond du Lac.

The apparent transition in ways to acquire tobacco that takes place between grades 8 and 10 may be largely do to the interaction of personal and environmental factors. Compliance check studies have found that merchants will sell tobacco to 16 and 17 year-olds at higher rates than 12- through 14-year-olds.[3,13] This may be due to personal scruples on the part of the seller and a more child-like physical appearance or manner on the part of the buyer. Adults who give tobacco to minors on the other hand, are likely friends or family members who underestimate or minimize the dangers of tobacco or do not wish to fall out of favor with their younger companions. Acknowledging their own immature appearance and lack of experience may translate into a lack of confidence on the part of the young buyer. The tentativeness of most younger tobacco users is supported by the data here that shows they regularly use any and all ways possible to obtain tobacco. Alternately or additionally, another factor may be lack of money. This would explain the greater reliance on "bumming."

As the young tobacco user enters high school, increasing physical maturity and experience together with increasing disposable income likely contribute to the narrowed assortment of methods used to acquire tobacco. Specifically, this seems to translate into more successes at purchasing tobacco from retail outlets. By the time they enter 12th grade, it is likely that all but the youngest in appearance and maturity, of those who are not 18, are able to freely purchase tobacco from businesses. This increase in confidence is evidenced here by the greater preference for asking a salesclerk for tobacco.

There can be little doubt that environmental factors such as rate of enforcement of laws against selling to minors, numbers and kinds of outlets, location of tobacco products within the outlet, advertising, and real or perceived norms regarding tobacco use all interact with the personal factors mentioned previously to determine the methods by which tobacco is obtained. Of these,

the lack of enforcement of laws against selling tobacco to minors has a well established, facilitating effect on the ease with which minors buy from businesses.

The most numerous types of businesses from which tobacco is sold are gas stations and convenience stores. This may be the primary reason they are named by far more tobacco using minors than any other type of retail tobacco outlet. Greater numbers may mean closer proximity to a schools or other youth gathering places (such is the case in Fond du Lac). Large numbers also mean greater overall accessibility even if some individual locations rigorously uphold laws against sales to minors. It may be that word gets around quickly as to which locations are lax at observing sales laws and it may be that only a few "easy marks" account for their popularity. Though these hypotheses remain untested, the popularity of bowling alleys (and many taverns, restaurants, and restaurant-bars) with younger tobacco buyers can be readily explained by the usual presence of accessible vending machines.

The percentages of respondents that report receiving free samples is consistent with that found in one of the only studies on the distribution of free samples to children.[14] Though the data from this survey substantiate that free samples are probably obtained only intermittently, questions remain on the sources of the samples. Future surveys may ask if the samples were obtained through the mail or from periodic events such as concerts, outdoor festivals, auto races, or other sporting occasions.

The results of this survey further support tobacco control policies that address youth accessibility to tobacco products. Buying of tobacco products from businesses can be effectively reduced by regular and systematic enforcement of laws prohibiting merchants' selling tobacco to minors. Unannounced compliance checks using underage youth have been shown to be effective at decreasing sales to minors.

Our data also strongly support the elimination of self service sales of tobacco. Banning the sale of tobacco through vending machines would greatly reduce accessibility in younger tobacco users, most of whom have not yet become nicotine dependent. Our data also imply that elimination of self-service display racks could markedly reduce over-the-counter sales as many youths pull tobacco from displays in lieu of asking a salesclerk. In addition, the placement of tobacco displays behind counters, in overhead racks that open to counter employees only, or in locked cabinets would effectively eliminate shoplifting, shown by the data presented here to be a significant method of obtaining tobacco.

A limitation of the survey, as with most surveys of student populations, is that the responses of chronic truants and drop-outs are not included. It has been demonstrated that this subset of teenagers exhibits higher levels of tobacco use.[15] For this reason, and because of the low response rates for grades 10 and 12, the percentages of cigarette and smokeless tobacco users presented here are in all probability, are under representations of the true numbers of tobacco users for these age levels.

Since these data are cross-sectional, the results only elucidate the methods and sources of tobacco acquisition at one point in time. To validate the implied transition from one tobacco acquisition method to another will necessitate following the groups as they move to the next surveyed grade level.

Caution must be exercised when interpreting data relevant to buying patterns for students in grade 12, given that over 40% of the respondents indicated that they were of legal purchasing age at the time of the survey.

Summary

The demographically similar communities of Fond du Lac and Manitowoc exhibit definite similarities in how tobacco products are acquired by students in grades 8, 10, and 12. Younger tobacco users rely on a variety of methods and sources for their tobacco where patterns of acquisition are more confined to buying from businesses as the students increase in age. It has been demonstrated that shoplifting can be a principal method by which tobacco is obtained. The results provide further motivation for meaningful enforcement of laws prohibiting sales of tobacco to minors and argue for the elimination of self-service merchandising of tobacco products.

Addendum

Data like those presented here are essential in identifying factors in a community which contribute to tobacco use by children and adolescents. Fond du Lac enacted a youth tobacco control ordinance on January 1, 1994 which included provisions that mandated compliance checks of local tobacco retailers and eliminated self-service sales of all non-carton tobacco products. On May 20, US Oil Inc., doing business locally as Express Convenience Centers, and 10 local retailers filed a lawsuit seeking to have the ordinance invalidated on the grounds that it was preempted by state statutes regulating the sale of tobacco products. On October 27, a Fond du Lac circuit court judge agreed with attorneys for the plaintiffs from the law firm of Foley and Lardner, that the state has "occuppied the field" with regard to regulation of tobacco products and ruled the ordinance invalid. This decision is not binding on other communities who may wish to enact a local ordinance that goes beyond simply adopting state statutes in an effort to reduce the access to and use of, tobacco by children.

This pointedly illustrates how weak state statutes can efficiently block communities from taking meaningful steps to decrease tobacco

Table 4.--Uusal location* of tobacco purchases by current tobacco users†(in percentages).

	8th††		1Oth§		12th‖	
	FdL¶	Man	FdL	Man	FdL	Man
Gas stations	51.3	46.7	59.6	56.6	68.6	46.5
Convenience stores	37.0	36.0	55.9	53.3	67.8	59.2
Food stores	16.4	9.3	30.1	20.5	31.4	23.9
Restaurants or Restaurant-bars	14.4	12.0	14.7	20.5	11.0	7.0
Department stores	7.5	5.3	14.7	11.5	15.3	9.9
Taverns or liquor stores	14.4	18.7	15.4	15.6	9.3	8.5
Drug stores	4.1	1.3	15.4	6.6	10.2	4.2
Bowling alleys	25.3	17.3	26.5	18.0	11.0	4.2
"I never buy cigarettes or smokeless tobacco."	14.4	18.7	6.6	9.0	6.8	12.7

Of 12th grade participants, 44% (Man) and 42% (FdL) reported their age to be 18 years or older, the legal purchasing age for tobacco in Wisconsin.This should be considered when looking at 12th grade responses.
*"From what types of places do you usually buy tobacco?" Respondents were instructed to choose all that apply. Percentages listed represent the rank order of answers chosen.
†"current tobacco user" is here defined as cigarette smoker, smokeless tobacco user, or both, at the time of the survey.
††Man: n=75; FdL: n=146
§Man: n=122: FdL: n=136
‖Man: n=71; FdL: n=118
¶FdL = Fond du Lac, Man = Manitowoc

use in young people and why preemption is a *sine qua non* for the tobacco industry. Communities, who are in the best position to protect the health of Wisconsin's children, can be rendered powerless to legally secure effective barriers against the seductive marketing of tobacco. The Fond du Lac experience should serve as a wake-up call to health care advocates, state legislators and all others who are concerned about this most significant threat to the health of Wisconsin youths. To do away with preemption of local tobacco control is to entrust those that know best to take care of their own.

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Blinded by the light: The folly of tobacco possession laws against minors

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Children are principally the creatures of example - whatever surrounding adults do, they will do. To solve the problem of education, childre n must be surrounded with equity and be equitably treated.
--Josiah Warren, American inventor and social philosopher.

Youth, though it may lack knowledge, is certainly not devoid of intelligence; it sees through shams with sharp and terrible eyes.--H. L. Mencken, American author and editor.

Before you beat a child, be sure you yourself are not the cause of the offense.
--Austin O'Malley, American oculist.

Within the context of the tobacco control movement has emerged reinvigorated efforts at preventing children and youth from smoking. These efforts have been fraught with a greater urgency because most people who use tobacco products begin doing so before they have attained the designated age of adulthood.[1]

One of the important variables in the youth-tobacco-use equation is youth access to tobacco products. Minors may obtain cigarettes from many sources, including parents and other adults, siblings, friends and businesses, and by "bumming," buying, stealing, shoplifting, and receiving free samples. Self-report surveys have shown that middle-school aged children and younger teenagers obtain tobacco products from friends more than from businesses, but by the time they reach 9th and 10th grade, businesses are overwhelmingly the source of choice for tobacco.[2,3]

At various times since the turn of the century, prevention and intervention efforts have included legally proscribing the sale of tobacco products to, and the purchase, attempted purchase, possession, and use of tobacco products by, children and youths. These laws as written (aside from the fine structures) and enforced imply that seller and minor buyer in possession are equally responsible and that legal penalties for minors are warranted given the harm associated with tobacco products. The remainder of this discussion will challenge the notion that legally penalizing or criminalizing minors for possessing, buying, or attempting to buy tobacco products has any value in a concerted and legitimate effort to reduce tobacco use in this age group.

Liberty, tobacco use, and minors

The use of tobacco is a legal right of people living in a free society. Despite the recent fervor surrounding the issue of tobacco control, the majority of our population--being of the mind that individual liberty comprises the bedrock on which our society rests--would no doubt agree with this statement. That there exists a Wisconsin state statute against minors possessing tobacco indicates that some people are of the notion that this right doesn't apply throughout the life span. The object of this discussion is not so much that tobacco use is a right of minors, but rather that they have the right not to be legally penalized for its use.

A principle argument against legally penalizing minors for attempting to buy, buying, or possessing tobacco, hereafter referred to as possession laws, can be made based on their running contrary to the concept of individual freedom. Limitations on personal freedom

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were articulated perhaps most thoughtfully in the essay, "On Liberty," by J. S. Mill who asserted in this well-known excerpt:

> The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. He cannot rightfully be compelled to do so or forbear because it will be better for him to do so, because it will make him happier, because in the opinions of others, to do so would be wise or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him or visiting him with any evil, in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of any one for which he is amenable to society is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.[4]

These thoughts have remained a fundamental principle underlying our decision to not legislate against, as Mill put it, "self-regarding" behavior. The majority of tobacco using youths may not fully comprehend the dangers of tobacco but no doubt would concur that tobacco use constitutes self-regarding behavior. Mill was quick to point out that these principles did not apply to all members of society:

> It is perhaps hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children, or of young persons below the age of which the law may fix as that of manhood or womanhood. Those who are still in a state of being taken care of by others, must be protected against their own actions.[4]

Clearly, children are to be treated differently. Mill seems to be confining this difference to the issue of self-regarding harms however, with the inclusion of the phrase, "must be protected against their own actions." The implication is that, unlike with adults, the law is a justifiable means to keep children from harming themselves. But whom are the laws to be directed against? Mill may not be clear in his writing on this point, but if the American legal record can be taken as a manifestation of his intent we find that these laws are directed at those to whom the care of children is entrusted, ie, adults. It is adults who have been held legally responsible for self-regarding harms in children and youths arising from their naivete, inexperience or desire. Subjecting youths to forfeitures for possession (or purchasing) of tobacco contradicts this tradition and hardly protects youths from self-inflicted damage. It seems odd that we do not legislate against youth for attempting suicide, willfully listening to music played at a deafening level or, for that matter, engaging in "consensual" sexual intercourse (assuming for the moment that this may be correctly categorized as a self-regarding harm), yet so many fail to think twice about criminalizing youths for possessing cigarettes or chewing tobacco.

With respect to the specific issue of harm to others inflicted by children or youths, Mill is silent but history is resonant. Minors and adults have been treated equitably if not equally by the law. Direct or indirect harm to others, when caused by minors, as with adults, has resulted in the minor being held legally responsible. Minors who engage in acts such as assault, burglary or vandalism, or in acts that predispose others to harm or contribute to mayhem, such as speeding or blocking a right-of-way, can and should be held legally culpable. It seems implausible that Mill would be in disagreement with this if the youthful perpetrators were at or above the age at which wrong can be distinguished from right.

So far then, a case has been made that possession laws are incongruous with both philosophical conceptions of how the law should be used to regulate individual behavior (for adults and children) and how the law has traditionally been put into practice. Tobacco, used in the customary way by minors, is largely a self-regarding behavior which should be dealt with insofar as the legal system is concerned, as other such behaviors have.

When tobacco possession or purchasing by minors becomes a behavior that harms others, then and only then should it become subject to criminal or administrative penalties. Tobacco use ceases to be entirely self-regarding in the form of environmental tobacco smoke (ETS).

Through valid scientific studies, ETS has been determined to be causal agent in the development of heart disease, chronic obstructive pulmonary disease, lung cancer, and a host of less life-threatening maladies. Smoking, in the absence of adequate ventilation and in the company of others is, therefore, a potentially harmful behavior to them. This makes it worthy of legal intervention and legitimizes sanctions against tobacco use by minors--so long as these sanctions are also placed upon adults.

Equity in law is not only in everyone's best interest, it is important in enlisting conformity to the standards of conduct that laws are meant to uphold. The inequity of current tobacco possession laws works against conformity with them. Holding both adults and minors accountable makes the law equitable and, thus, justifiable. There are few other essentially self-regarding behaviors that we hold kids themselves legally accountable for, while at the same time excluding adults who

indulge in the same behavior from legal repercussions. It seems worthwhile to briefly deliberate on one such behavior--possession and use of alcoholic beverages.

Supporters of tobacco possession laws will generally justify them on the basis that we treat alcohol use and possession by minors similarly. The issue of the effectiveness of penalties against the purchase and possession of alcohol notwithstanding, more justification for them may be mustered based on inherent differences in the pharmacological properties of alcohol and tobacco and in the culturally dictated (especially age-related) pattems in which alcoholic beverages are consumed. Conventional use of alcohol by typically inexperienced minors more often than not results in intoxication. Clumsiness and in attentiveness are common results, however, the depressant effects of alcohol may also act in concert with current expectations and emotional immaturity to precipitate aggression or other irresponsible behavior. Not only will the risk of self-inflicted injury or other misfortune increase, but the likelihood of the user harming anothers' person or property escalates as well. Herein lies at least some credible bit of justification for the existence of alcohol "minor-in possession laws" based on the protection of the interests of others.

Intoxication from tobacco, however, does not normally occur and there is no innate pharmacological effect of tobacco to which either unintended or deliberate transgregsions against others can be so causally linked. Intoxication is the primary issue with alcohol use by minors. Addiction or dependency, which laws are characteristically impotent against, is the primary issue with tobacco use by minors.

The similarity between adult and youth tobacco dependency and the propensity for even occasional young tobacco users to slide into addiction has been clearly established.[1,5,6] Adolescents smoking openly on sidewalks outside schools, for example, are much more likely to be regular daily smokers--a behavior indicative of, or preceding, addiction. Based on research relating to the use of other addictive substances, fines and--an increasingly popular substitute--coercion into "education programs" or "community service" have little with which to commend them for addressing tobacco addiction.

The line of thought developed to this point has proposed that legal proscriptions on minors' attempted purchase, purchase or possession of tobacco products are discordant with the principles of individual liberty (embodied here by Mill's essay) and the laws that parallel and uphold these principles. This fact, philosophically, argues against their use as a means of tobacco control. Philosophy aside, can their existence be justified from a utilitarian perspective? If they are successful at deterring or reducing tobacco use in children, it may be in the best interest of children's health to overlook this inconsistency. On the other hand, if they have little or no functional value, the case against them becomes secure.

A history

Laws addressing tobacco use by youth in Wisconsin have existed since 1891, when the first restrictions were enacted against persons selling or giving tobacco products to minors. Section 4608v of Chapter 463, Wisconsin statues, enacted in 1907, prohibited the use or smoking of tobacco, cigarettes, or cigars by a person under 16 years in essentially any public place or on any public land except when accompanied by a parent or guardian became the first state law on possession by minors. In 1915, a provision was added making it a misdemeanor subject to a fine of not more than $5 if a minor refused to disclose the source of tobacco to law enforcement or probation officials, truant officers, or teachers. This was amended in 1919 to include misrepresentation of age by the minor and the penalties were increased to include a fine of not more than $25 and a prison term of not more than 30 days. In addition, if a male violator was under 17 years old or a female under 18, they were considered delinquent and subject to juvenile court proceedings.[7]

The disclosure of source provision was repealed in 1955. In that same year, the Child Welfare Committee of the Legislative Council, as part of a comprehensive revision of the Children's Code, recommended repeal of the use and possession prohibitions based partly on the assertion that these laws, "for the most part, are completely ignored" (Bill No. 444, Wisconsin Stat, note to sections 352.50 (1) and 352.49). This repeal was enacted also in 1955.

The restriction on misrepresentation of age for the purpose of receiving tobacco products by minors remained out of Wisconsin state statutes until 1987, when Act 336 once more incorporated them into the Children's Code setting the legal age at 18 and adding prohibitions against buying or attempting to buy tobacco (unless for the purpose of resale as a condition of employment by a retailer who sells tobacco products). In addition, a section was added, among others, that preempts localities from enacting ordinances that do not strictly conform with the state language. In 1991, Act 95 added a prohibition against possessing tobacco except in the course of employment as described above. Although neither of these statutes bans the use of tobacco, using tobacco without possessing it becomes a practical impossibility. The penalty for minors is a forfeiture not to exceed $25.

It is currently illegal for anyone under 18 to attempt to purchase, purchase, or possess (except in the course of employment) tobacco products under ss 48.983 of the Wis-

consin Children's Code. Minors cited under this statute will be subjected to juvenile court proceedings and the revenue from the forfeitures go to the state. Because of this, counties, towns, or villages are motivated to adopt 48.983 as a local ordinance where the fine may be remitted directly or, if challenged, handled through circuit court. The money collected then goes to the locality.

Enforcement

Tobacco possession laws are almost never enforced as state statutes and rarely, in proportion to the prevalence of violations, as local ordinances. This has been true without exception since the first state statute was created in 1907. If per chance they are enforced, tobacco use may likely be a secondary issue. Examples are mentioned below.

Police departments are willing to devote little time or personnel to enforcing these laws, because officers are already spread too thin to deal with the deluge of other, more pressing, matters. When citations are issued, the majority are issued by patrol persons or police-school liaison officers in the proximity of schools, to smoking students (smokeless tobacco--the fastest increasing form of tobacco use--remains virtually unchallenged). This was the case for the 41 of 46 citations written in Fond du Lac since a possession ordinance became effective Jan 1, 1994. In the rare cases where citations are written, the next issue then becomes the collection of the forfeitures--often a task that meets with low success rates. It is almost inconceivable that extra moneys appropriated to local police departments, either specifically or in a supportive fashion, would be targeted for the enforcement of tobacco possession laws.

Even if the police were of a mind to enforce a local ordinance, given the portability and ease of use of cigarettes (even more so for smokeless tobacco), it is extremely unlikely that the rate of apprehension would be such to have a meaningful deterrent effect on the prevalence of tobacco use. Supporters of these ordinances will maintain that their existence plays an important role in deterring tobacco use among youth, yet there are no empirical studies on deterrent effects of tobacco possession laws.

Deterrent effects of related laws, however, have been studied. As Ross has stated in reference to drunk driving laws:

> General deterrence is a theoretical principle that predicts suppression of behavior when subjected to a threat perceived as swift, certain, and severe. The principle is a psychological one, centering on perception.[8]

Though a $25 fine and police intervention may be perceived as severe by some children or adolescents, a history of nonexistent enforcement has disarmed these ordinances of any perceived swiftness or certainty of apprehension or punishment. In an earlier work Ross attributed any deterrent successes of drunk driving laws to an exaggerated perception of certainty of apprehension.[9] Moreover:

> The achievement of long-range normative and behavioral changes as a consequence of deterrent threats is a plausible expectation, provided that the threats are initially credible. The best evidence of credible threats would be immediate modification of behavior so as to avoid them, that is, simple deterrence. The lack of an immediate response to a threat would suggest a lack of credibility for it, which is hardly likely to render it capable of performing educational or habit-forming functions.[8]

That there may be some salvageable deterrent effect by possession laws seems to be supported by a 1994 survey of more than 2,000 8th, 10th, and 12th grade students in the Fond du Lac and Manitowoc school districts. Those who had never used tobacco and those who had quit were asked to choose any number of 11 listed reasons that were "most important in your choosing not to use or continue." The reason, "there is a law against people my age smoking" was chosen by 26% of non-using and 14% of ex-using 8th and 10th grade students, it was chosen by larger percentages of 8th grade students than 10th grade. Noticeable was the markedly smaller percentages of 10th grade ex-users in Manitowoc, where a possession ordinance existed at the time of the survey, who cited that reason. Only, "because it's too difficult to buy cigarettes" was chosen less. In contrast, "smoking is bad for health" was chosen by 68% of non-tobacco users and 47% of ex-users.[10] It must be reiterated that respondents could choose as many reasons as they wanted. Most of the participants chose several.

There have been no scientific studies to support these findings and the relatively diminutive effects alluded to by the foregoing are disavowed by the grim realities of current trends. Tobacco use by minors has gone up consistently since the instatement of possession and use laws in the first decade of this century. Those under 18 currently use tobacco at higher rates than the adult population and continue to openly rely on businesses as their primary sources of tobacco.[2,11-14] These hardly indicate modifications of behavior so as to avoid a credible threat and stand as lucid testimony to the failure of these laws as substantive agents of deterrence.

Symbolism

A lack of any meaningful deterrent effect may be acknowledged by supporters of possession ordinances, yet many continue to cling to them for their so-called symbolic significance. Simply put, supporters fear that lack of legal sanctions against minors "sends the wrong message,"

implying that tobacco use is not harmful or not socially unacceptable. The Committee on Preventing Nicotine Addiction in Children and Youths of the Institute of Medicine said it most succinctly in addressing these apprehensions:

> In the committee's view, such speculative fears are groundless--social disapprobation is (or should be) strongly communicated by the laws on distribution, by warning labels, and by all of the other policies outlined in this report. Young people will not miss the point simply because their disapproved conduct is not against the law.[1]

Symbolic and selective laws against tobacco use continue to exist for some of the same reasons that tobacco use is attractive to a certain subset of youth. Youths appear more frightening, intimidating, or perhaps aberrant when they are smoking or using smokeless tobacco. These appearances mask the inadequacies that have lead them to take refuge in tobacco. We as adults take refuge in meaningless laws. They help us compensate for the fear and inadequacy we feel when we have to deal with these youths. Neither group is served well by the methods chosen.

Alternate uses of ordinances

Tobacco possession ordinances are often used by schools for purposes related to crowd control, complaints from nearby private residents, public image, and to supplant or supplement existing school sanctions against tobacco use such as detention or suspension. To be sure, a $25 fine will generally leave an impression in the mind of an adolescent. In this way, a fine may have an immediate desired effect on (a) person(s) in a particular place and time. Esoteric benefits achieved by schools, however, have failed to translate into measurable prevention or reduction in prevalence of tobacco use in minors.

Results from the Manitowoc survey mentioned earlier revealed no difference in past 30 day reported smoking rates for 8th grade students compared to Fond du Lac, but the percentage of 10th grade smokers was appreciably higher.[3] It should be noted that Manitowoc, which is demographically very similar to Fond du Lac, recorded 59 tobacco possession citations to minors in 1993. In the larger scheme of things, the enlistment of tobacco possession laws by schools can actually contribute to their counterproductiveness. Any short-term positive gains tend to erode quickly when enforcement eases up, which is an inevitability. A decrease in prevalence of tobacco use, however, is not one of these gains.

Then there is the issue of equity again. If students are not fined for cheating, skipping class, or insubordination (not to mention disrespect, fighting, or disrupting class) why should they be fined for tobacco use? The answer is to issue citations for none of these, including tobacco possession.

Law enforcement officials are reluctant to enforce tobacco possession laws, yet paradoxically, they are often quick to endorse their adoption at a local level. Symbolic meanings often play an important role in this. Another reason cited is that, "state statutes have historically been adopted at a local level," a reason refuted by the relatively small number of Wisconsin municipalities that have done so (and even fewer who quickly adopted ss 48.983 when it became law in 1991). Perhaps the primary reason however, lies in the ability to use the ordinance selectively, as a means by which to stop, question, or cite someone for a reason secondary to tobacco control. This may be the case at schools for incidents mentioned above or for retaining someone suspected in a certain crime. It goes without saying that this has little to do with decreasing tobacco use in young people. Such alternate applications of tobacco possession laws violate the spirit of the purpose for which they were intended.

Tobacco as culture

The foregoing discussion has attempted to illustrate the considerable deficiencies of tobacco possession laws. But if these laws are not helpful, they are also not benign. As a prelude to directly addressing this assertion, a brief examination of the unique relationship we have with tobacco, among many other harmful substances, is in order.

The cigarette, as the most prominent example among tobacco products, is the most efficient drug delivery system ever devised. It is the only system that provides for the repeated self-administration of non-incapacitating doses of a dependency-producing drug and yet allows the user to keep both hands free for other activities. It is extremely portable and user-friendly so it is almost effortless to use, literally, anywhere. An imperfection of the delivery system (smoke) is the dangerous element. Intoxication does not occur, but the rapid delivery and subtle effects of nicotine provide an almost immediate reinforcement of behavior or affect. The most deleterious effects of smoke are not immediately detectable but certain and quick dependency ensures their cumulative effects. Tobacco is used from the time we rise to the time we sleep, at work, with meals, within most family and individual contexts (including the most intimate), in most forms of transportation, in most types of recreation and at many religious functions. These characteristics, together with the historical importance of tobacco as an economic commodity and almost universal acceptance of tobacco use, have enmeshed our society with tobacco to a degree wholly unlike any are comparable substance. In short, tobacco use has become fully integrated into all aspects of contemporary American culture.

As to the matter of influencing how tobacco is used, enforced regulations on those who market and sell it have been essentially non-existent. Formal (eg, tobacco or smoke-free policies) and informal (e g, individuals proscribing use in homes) sanctions against the use of tobacco, including the use by minors, are a relatively new phenomenon. The importance of limiting access to tobacco by youths, although historically recognized by a few, has been a dissonant note in a symphony of cultural approbations. Hence the current reluctance of many, including law enforcement, to raise a hand against tobacco interests in their pursuit of the young.

Those responsible for the current stature of tobacco in our society are adults. That we entice children and youths, either directly by modeling or indirectly by allowing tobacco to be indiscriminately glamorized and peddled to the young by irresponsible business interests, and then turn around and criminalize them for the very behavior they have been encouraged to emulate amounts to institutionalized entrapment. Attempts by adults to "spread the responsibility around" through symbolic gestures of fining a selected group of minors constitutes an abdication of the responsibility to face up to our own accountability.

Accountability

Youths recognize and resent the inequity represented by these laws, thus adding rebellion and "forbidden fruits" to the list of attractions to tobacco use. Moreover, selective enforcement, when perceived to be used in a pejorative way against those youths for whom tobacco use has become a defining characteristic (eg, the chronically truant, low academic achievers, those of low socioeconomic status, etc), may only further entrench their behavior and encourage disregard for law enforcement personnel. Symbolic laws which have no philosophical justification, are really not meant to be enforced, cannot or will not be enforced given the realities of time and personnel, and thus may only serve to engender disrespect for laws in general. This point must be weighed carefully. Do we really want to invest this kind of power in those that will make a mockery of the law? These are all ways that tobacco possession laws are counterproductive.

Within a culture, informal social controls such as face-to-face interventions by family and friends, much more so than formal controls (laws, governments, health care personnel, etc), determine behavior. Moreover, informal controls are more likely to be strong if supported by formal social controls but cannot be created by them. Tobacco control policies that tend to penalize individual self-regarding behavior will not force family and friends to change the way they view tobacco use. There is a real temptation to use tobacco possession laws to supplant less formal rules or policies. In this way, possession laws may come to preempt more salient informal controls. This preemption can have the counterproductive effect of allowing families, friends and schools to relinquish their control over minors' tobacco use ("the police will handle it") and once this is done, this control is difficult to regain. Such may be the case with schools that fine minors in addition to, or instead of, invoking routine school policies. As mentioned previously, fines may well have an immediate effect, but in the long run schools and families will be better served by thoughtfully constructing more adroit policies or guidelines, such as those that increase the perceived certainty and immediacy of apprehension and punishment, rather than those that rely on law enforcement.

Those minors who are blocking sidewalks, littering, intimidating others, trespassing, etc, should be held accountable by the use of legal penalties. Fines levied for tobacco use to get at these or other disapproved behaviors will neither decrease the tobacco use nor effectively address the pertinent underlying issues and, as noted earlier, can be counterproductive. None of the preceding is meant to suggest that minors who engage in tobacco use should not be, as Mill put it, persuaded, entreated, remonstrated or reasoned with to cease. Informal interventions on tobacco use by a police officer, school official, teacher, health care provider, friend, or family member are paramount to shaping behavior--especially to younger individuals--and need to be encouraged. Furthermore, it should be the priority of a community to design programs and enact policies that invest the authority and resolve in people to informally intervene.

A community environment that reinforces non-tobacco use as the social norm will provide the greatest hedge against children and youths using tobacco and concomitantly encourage responsibility. This is best accomplished by the creation of policies that are equitable and ethical. First and foremost, statutes against those doing trade in tobacco selling to minors should be systematically enforced through the use of random, unannounced, and frequent (3 times/business/year) compliance checks using under-age youth as buyers. Research has verified their effectiveness.[14] Similar laws should not be instituted against parents, friends, siblings, etc. As minors find that they will no longer be able to buy at the local convenience store, buying attempts will likely dissipate rapidly. It is also likely that those minors who continue to use tobacco will rely more on friends as sources. This is a problem, but wlll be indirectly addressed as the community shifts to a non-use norm.

Secondly, tobacco use should be prohibited by law or policy wherever the effects of use pose a health or other threat to others. So-called

smoke-free policies and their attendant penalties should apply to both adults and juveniles. These policies vigorously reinforce the idea of a more auspicious community norm. Finally, parents and other adults should be provided with easily accessible means of quitting tobacco use. Parents, especially, play an important role in continuation of smoking by minors.[1] Their quitting lends further credibility to a coordinated effort. All of these in concert will provide necessary cues and disincentives for children to neither initiate nor continue tobacco use and provide both an equitable and ethical basis for a more durable change in behavior.

Possession laws with their inherent inequity and focus on individual as opposed to group behavior contravene this process. Responsibility and accountability are instilled by the weight of informal commmunity opinion.

Tobacco industry support

Adopting possession laws as local ordinances will also effectively preclude communities from using minors in compliance checks as any possession or attempt to buy will be illegal. City attorneys may be reluctant to issue waivers to departments other than police. This will either, by default, make police responsible for conducting compliance checks (which they do not want to do and therefore, will endorse the most convenient over the most expedient) or knock the "teeth" out of the checks.

The tobacco industry of course, is aware of this and much more. It has monitored the increases in adolescent tobacco use, along with the failure of minor possession ordinances since their inception (in Wisconsin) in 1907. Because they are not meant to be enforced, the industry exuberantly supports them knowing better than anyone that the laws do not pose a threat to their most prized consumer base. This puts them in good standing with many citizens, smoker and non-smoker alike, because it deflects criticism, helps create a facade of sincerity for preventing children from using tobacco and "getting tough" with kids who break the law. At the same time they push for unenforceable, preemptive state laws against businesses selling to minors, continue to glamorize tobacco through the use of advertising attractive to children, and provide retailers with lucrative incentives to market tobacco in such a way that it is easily accessible to minors. Possession laws end up being tantamount to de facto collusion with tobacco companies in targeting children and youth.

Lack of scientific support

If tobacco possession laws were thought to be effective, they would be studied by the scientific community. Currently, there is no attention accorded the topic. This in itself speaks volumes as to the merit of these laws.

Mesmerized by the Zeitgeist

A strong case has been made up to this point against the use of tobacco possession laws for minors. Yet despite their counterproductive and disreputable nature, there are many, including legislators and even tobacco control advocates, who support them. For example, members of both houses of the Wisconsin State Legislature were asked in an unscientific survey, what types of penalties they favor for non-compliance with tobacco statutes. Of the 32 respondents from the Wisconsin State Assembly, 56% were in favor of fines on minors. Half of the 12 Wisconsin State Senate respondents agreed with their fellow legislators.[16]

The upsurge in crime committed by minors is receiving intense publicity. It has cast a shadow over young people and has been seized by nervous policy makers eager to appease the demands of the voting public. Predictably, corrective measures are focusing on the punitive end of the spectrum with little attention given to changing environments that facilitate misbehavior. Tobacco use has historically been a characteristic that significantly correlates with problem behavior (including crime) in adolescents. There is real risk of legislators at every level of government becoming transfixed by the emerging spirit of the times and lumping tobacco use and attempts at buying under the rubric "juvenile crime." This will ensure the criminalization of thousands of children and youths and will further belie the issue of youth access to tobacco products. "Getting tough" on tobacco use by minors really means legally backing off kids and putting the screws to adults.

Conclusion

Preventing and reducing tobacco use in minors remains a formidable challenge given the ingrained status of tobacco in our society. Legislation can play a critical role, but laws that penalize minors for purchasing, attempting to purchase, or possessing tobacco products are misguided attempts to attain the desired end. Such laws have nothing with which to rationalize them on philosophical grounds and their inequitable nature tends to disenfranchise rather than deter. They remain symbolic shells with little substance to offer and within a broader context will only marginalize more expedient efforts.

As the light of reason (and reasonableness) illuminates the way of tobacco control, circumspection will prove to be our most useful ally. To best serve our young constituents let us allow the light to reveal the traps and dead-ends, rather than in our earnestness gaze directly into it and become blinded by its intensity.

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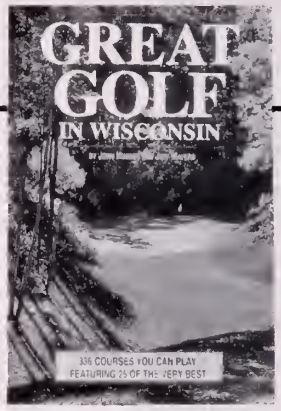
Physician self-referral prohibition extended

On Jan 1, 1995, provisions of the 1993 Omnibus Budget Reconciliation Act (OBRA '93), known as Stark II, go into effect. The provisions expand the prohibition against physician self-referral of Medicare and Medicaid patients beyond clinical laboratory services that have been effective since Jan 1, 1992. Under Stark II, self-referral prohibitions include physical therapy services; occupational therapy services; radiology or other diagnostic services; radiation therapy services; the furnishings of durable medical equipment; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

Physicians in group practice need to be aware of the implications of the Stark II law. No physician who is a member of a group may receive compensation based on the volume or value of referrals by the physician except that; (1) a physician may be paid shares of overall profits of the group as long as the share is not determined in a manner that relates to the volume of referrals; and (2) a physician may be paid a productivity bonus based on services personally performed or supervised by the physician (or by another physician in the group) as long as the bonus is not determined in a manner that relates to the volume of referrals.

The Stark II prohibitions will have an effect on many physicians, not only those in group practice. The SMS recommends that physicians with Medicare and Medicaid patients, who have self-referral arrangements, should review these arrangements with knowledgeable legal counsel to help assure compliance with the Stark II law.❖



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Medical waste management rules promulgated

Pursuant to authority granted in Chapters 144 and 159, Wis Stats, the Department of Natural Resources (DNR) has promulgated administrative rules governing medical waste management procedures. The purpose of the rules is to minimize the amount of solid waste which must be landfilled or incinerated and to promote reuse and recycling. The rules also are designed to promote safe ways to manage medical waste and to monitor the transport and disposal of medical waste.

The rules impose safety requirements on all those who generate infectious waste. The safety requirements address waste separation and treatment, and containment, handling and disposal of infectious waste. There also are requirements for those persons storing, transporting and treating infectious waste, as well as requirements for those who operate waste treatment and disposal facilities.

The rules also explain the medical waste reduction policy statutorily required of clinics, nursing homes and hospitals generating 50 or more pounds per month of medical waste. All generators of medical waste are required to keep records with regard to the amount of waste sent off-site for treatment, but only those generating 50 or more pounds per month are required to formulate and implement a medical waste reduction policy. The medical waste reduction policy must include a waste audit, a waste reduction plan and a plan for implementation.

The waste audit is to address current solid waste management practices by looking at source areas, waste types generated in each source area, quantity of medical waste, medical waste generation rate and waste management practices. It is to be conducted before completing the medical waste reduction plan and be conducted every 5 years.

The waste reduction plan is required to include the medical facility's internal goals, objectives and a timetable for reducing the amount of medical waste generated.The goals must include a specific numeric goal expressed in terms of a medical waste generation rate, prevention of mixing of non-infectious waste with infectious waste, a reduction in the use of disposable items, appropriate education and training for staff, and monitoring and assessment of waste reduction efforts.The waste reduction plan also must describe current efforts related to medical waste management, as well as past efforts to reduce medical waste. The plan must identify the employee positions responsible for portions of the plan, and progress reports are to be submitted to the DNR on forms provided by the DNR.

The rules suggest that the waste reduction plan include as priorities waste reduction, reuse by appropriate reprocessing and recycling when appropriate. Facilities also should consider costs, probable adverse effects on patient care and worker safety, recycling laws and options, and the availability of products and equipment.The rules also explain the use of manifests which are statutorily defined as "a form used for identifying the quantity, composition, origin, routing and destination of medical waste during its transport and disposal." Those entities transporting less than 50 pounds of un-

Continued on next page

Minnesota physician license surcharge appealed

Minnesota legislation, which became effective Oct 1, 1992, mandated the imposition of an annual license surcharge of $400 against each physician licensed by the Minnesota Board of Medical Practice who resides in Minnesota or the states contiguous to it.

In the lawsuit *Ubel v State of Minnesota*, C7-94-300, the plaintiff physicians, those whose Minnesota medical licenses were initially issued or renewed between April 1 and Sept 30, 1992, sued the state in a class action to declare the retroactive application of the statute not authorized by law and unconstitutional. They requested relief from the imposition of the $400 surcharge by the board on those licensees for that time period. Physicians who are similarly situated are automatically members of this class unless they specifically withdraw. Both the trial court and court of appeals decided in favor of the defendants.

On Sept 16, the Minnesota Supreme Court agreed to hear the plaintiffs' case. If the Minnesota Supreme Court finds in favor of the plaintiff class, then the physicians who have paid or are being pursued by Minnesota through a collection effort for payment of the $400 imposed for that time period should receive relief and a refund of their monies.❖

Continued from preceding page
treated infectious waste away from the place where the waste was initially generated, and those generators transporting infectious waste only on private roads on the same property where the infectious waste was generated and using vehicles owned or leased by the infectious waste generator are exempt from the rules governing manifests. Manifests will be available from the DNR. The generator is required to identify the place of origin of the infectious waste (i.e. the facility), a contact person at the facility, the route of the infectious waste beyond where the waste was generated, the destination of the waste, the composition and quantity of the infectious waste and the signature of the authorized representative of each facility or transporter handling the waste. The manifest is designed to document the journey of the infectious waste on its way to a disposal facility.

The rules become effective Nov 1. Questions about the medical waste management rules should be directed to Barbara Gear of the DNR. Gear is the medical waste coordinator for the DNR and may be reached at (608)266-2111. Copies of the rules will be available for sale by Nov. 1 and can be ordered from the Department of Administration, Document Sales, PO Box 7840, Madison, WI 53707-7840. Phone orders for the rules should be directed to 1-800-362-7253 if a credit card will beused for payment. All other phone inquiries should be made to (608)266-3358.❖

Do You Know The Physician-Citizen of the Year?

The State Medical Society of Wisconsin is asking the people of Wisconsin to nominate doctors for the Physician-Citizen of the Year award. The award was created to recognize the civic, cultural, economic, charitable and health care services provided by doctors to their local or state communities. Here are the criteria:

- The doctor must be a Wisconsin resident.
- The doctor must be either an MD or a DO practicing medicine in Wisconsin.
- Except in unusual circumstances, the service to the community should be uncompensated. (Preference is given to current service over lifetime service.)
- Previous winners of the award are not eligible. *(The Medical Society will notify you if the doctor you nominate is a previous winner.)*
- The deadline for submitting nominations is **Feb. 3, 1995.**

How do you nominate someone?

Write to the Medical Society and provide:

- The name of the doctor.
- The doctor's home or office address.
- Your name and address.
- Why you think the doctor deserves to win: What has the doctor done for the community?
- Send to: Commission on Public Information, State Medical Society of Wisconsin, P.O. Box 1109, Madison, WI 53701.

Nominating Committee compiles slate of candidates; Dr Ulmer nominated for 1995 president elect

THE CHAIR OF THE SMS Board of Directors, Richard Ulmer, MD, a Marshfield cardiologist, has been selected by the nominating committee to seek the position of president elect at the society's April annual meeting.

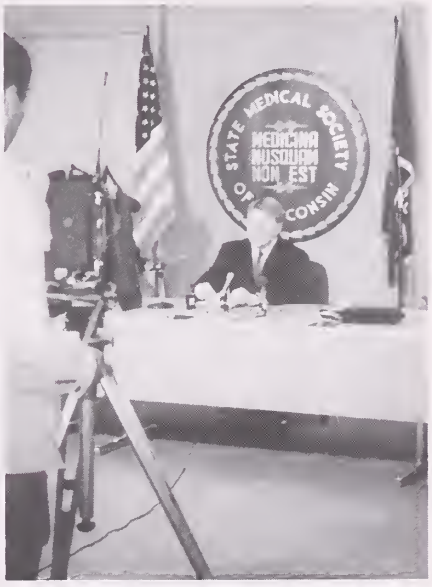
The House of Delegates Nominating Committee approved the following slate of nominees Oct 8: president elect for 1995-1996--Richard H. Ulmer, MD, of Marshfield; speaker of the House of Delegates for 1995-1997--Sandra L. Osborn, MD, of Madison; AMA Delegates for calendar years 1996 and 1997--John D. Riesch, MD, of Menomonee Falls; Kenneth M. Viste, Jr., MD, of Oshkosh; Susan L. Turney, MD, of Marshfield to fill an unexpired term for calendar year 1995 and for calendar years 1996 and 1997; AMA alternate delegates for calendar years 1996 and 1997--Kevin T. Flaherty, MD, of Wausau, Robert J. Jaeger, MD, of Stevens Point. If Dr Turney is elected by the 1995 House of Delegates as an AMA delegate, the committee is prepared to nominate Paul J. Leehey, III, MD, of La Crosse, as an AMA alternate delegate for calendar year 1995 and for calendar years 1996 and 1997.❖

AMA seeks recommendations for committee appointments

EACH YEAR, the AMA solicits recommendations from various sources, including the SMS, for possible appointment to a variety of committees that respond to and reflect the AMA's continuing responsibilities in medical education. The deadline is Feb 1, 1995.

Two vacancies are expected by the end of 1995 on the Graduate Medical Education Advisory Committee and one is expected on the Continuing Medical Education Advisory Committee. The following vacancies are expected for the residency review committees of: allergy and immunology (1); emergency medicine (2); ophthalmology (2); orthopaedic surgery (1); pathology (1); pediatrics (1); preventive medicine (occupational medicine) (2); and urology (1).

All nominees must be AMA members, and nominees for residency review committees should have experience and interest in graduate medical education. Contact Don Lord at the SMS, 1-800-362-9080 or, in the Madison area, (608) 257-6781.❖



SMS President Richard Roberts, MD, JD kicks off the CHILD SAFE program with a news conference.

Physician briefs

The * indicates a member of the SMS.

Ann R. Berlage, MD,* of Beaver Dam, was recently elected chair of the board of directors of the Wisconsin Academy of Family Physicians at the group's 46th annual meeting in Oshkosh. She served the past year as president of the WAFP, the first female president in the 46-year history of the association. Her father, Dr Charles Steidinger, also served as president of the WAFP in 1982. They are the first father and daughter to serve as president of any state chapter of the AAFP.

Robert A. Braastad, MD, a cardiology specialist, joined the cardiology practice of Dr Michael D. Becker, St. Francis. Dr Braastad received his medical degree at Emory University School of Medicine in Atlanta.

Richard A. Dart, MD,* was named the Addis Costello Internist of the Year at the annual meeting of the Wisconsin Society of Internal Medicine held in Delavan. Dr Dart is vice chair of the Department of Nephrology and Hypertension at the Marshfield Clinic. He is also clinical associate professor of medicine, collateral faculty, at the University of Wisconsin-Madison.

Marc Erickson, MD,* has joined Medical Surgical Associates and the medical staff of Fort Atkinson Memorial Hospital. He received his medical degree from the Medical College of Wisconsin in Milwaukee and completed his residency at Michigan State University-Butterworth Hospital, in East Lansing, specializing in general surgery.

Michael Garren, MD,* a general and vascular surgeon, has joined Physicians Plus-Jackson, in Madison.

Dorothy Ganick, MD,* a pediatric oncologist in Green Bay, has established a solo practice, the Pediatric Hematology Oncology Clinic. She was formerly affiliated with Webster Clinic.

Daniel L. Johnson, MD,* a Menomonie internist, recently was installed as president of the Wisconsin Society of Internal Medicine during the society's 39th annual meeting and scientific program in Delavan. Dr Johnson is board certified in internal medicine and is a practicing internist at the Red Cedar Clinic in Menomonie where he also is a member of the board of directors.

Kevin Kuntz, MD,* a psychiatrist, has joined Physicians Plus psychiatry department in Madison.

Joseph J. Mazza, MD,* has won the 1994 Distinguished Internist of the Year award from the Wisconsin Society of Internal Medicine at the group's annual meeting. Dr Mazza is a past president of WSIM and a past governor of the American College of Physicians, Wisconsin Chapter. He is currently director of medical education at the Marshfield Medical Center. He has been head of the section of hematology at the Marshfield Clinic since 1982.

Medical students hear of need for involvement

Making an informed decision on election day was the goal of this year's UW-Medical School's Legislative Awareness Week, Oct 25-28. Second District Congressional candidates, Democrat Tom Hecht and Republican Congressman Scott Klug both spoke to the students about the health system reform proposals they support.

On Tuesday, Tom Hecht stressed his support of a single-payer health care plan, while on Wednesday, Rep Scott Klug said he supports a managed-competition health care reform model. On Thursday, the students heard about how critical it is for physicians to get involved in grassroots lobbying and to be involved in local campaigns.

Mike Kirby, SMS government relations director, also explained that physicians are known at the state capitol for their lack of political involvement and he urged the students to change that reputation when they become physicians. On Friday, SMS President Richard Roberts, MD, JD, discussed his CHILD SAFE initiative and encouraged the students to be future community leaders. Legislative Awareness Week was sponsored by the AMA Medical Student Section, the SMS and the Dane County Medical Society. ❖

Edwin L. Overholt, MD,* received a special recognition award from the Wisconsin Society of Internal Medicine for his role in fostering cooperative relations between the Wisconsin Society ofInternal Medicine and the American College of Physicians, Wisconsin Chapter. Dr Overholt retired in 1993 as the director of medical education at Gundersen Medical Foundation and Gundersen Clinic-LaCrosse Lutheran Hospital. He is currently the board president of the Southwest Area Health Education Center.

Lorel Rolak, MD, has joined the staff of Marshfield Clinic. He served his residency in neurology at Baylor College of Medicine Affiliated Hospitals in Houston. He earned his medical degree from the University of Arizona College of Medicine in Tucson.

David Murdy, MD,* a specialist in internal medicine and geriatrics at the Riverview Clinic of Dean Medical Center, has received certification as an FAA medical examiner to provide second and third class physician examinations. He is currently the only FAA qualified examiner in Rock County.

George Pagels, MD,* most recently a physician administrator with the Marshfield Clinic, joined the administrative team of All Saints Healthcare System, Inc., in Racine. Dr Pagels, who was medical director of quality assurance at the Marshfield Clinic, became the vice president for medical affairs, a newly created position in the All Saints system.

A. Hilton Parmentier, MD,* is appointed medical director of the McBride Center in Madison, which provides outpatient services in psychiatry and addiction medicine.

Mary F. Schroeder-Capelli, MD,* of Greenfield, has joined the staff of the Aurora Health Center in Kenosha. She is an ophthalmologist. Dr Schroeder-Capelli graduated from the Medical College of Wisconsin, Wauwatosa, and completed her internship at St. Luke's Medical Center in Milwaukee. She completed her residency in ophthalmology at the Medical College of Wisconsin, where she was chief resident.

Daniel R. Sherry, MD,* of Ellsworth, was elected President-Elect of the Wisconsin Academy of Family Physicians at the organization's annual meeting in Oshkosh. Dr Sherry will take office in August 1995.

David Simenstad, MD, has joined the staff of Marshfield Clinic-Lakeland Center, after completing a fellowship in total joint replacement at the Intermountain Bone and Joint Institute, LDS Hospital in Salt Lake City.

Diane L. Staudinger, MD, a family physician, recently joined the team of doctors at Two Rivers Clinic. She received her medical degree at the UW Medical School in Madison and completed her residency program at Appleton Family Practice.

Virginia Villalon, MD, has joined the Marinette and Menominee Clinic, specializing in internal medicine and nephrology. Dr Villalon is also a member of the Bay Area Medical Center medical staff, serving as the new medical director of the dialysis department. She recently completed a fellowship in nephrology at Wayne State University Medical Center in Detroit, where she also conducted her residency in internal medicine.

Kenneth M. Viste, Jr, MD,* was elected chair of the AMA Council on Legislation at its meeting in Chicago in September.

Michael A. Wilson, MD,* president of Dean Medical Center, has been elected Midwest section director of the Medical Group Management Association, and now serves as a national officer. Dr Wilson has been with Dean Medical Center since 1990.❖

SMS Executive Vice President Thomas Adams greets Gov Tommy Thompson at SMS headquarters. Thompson visited the SMS to accept the WISPAC endorsement.

County society news

Ashland-Bayfield-Iron. The following physicians have been approved for membership in the Ashland-Bayfield-Iron County Medical Society: James E. Lean, MD; John A. Sauer, MD; and Charles W. Snyder, MD.

Columbia-Marquette-Adams. New physicians approved for membership in the Columbia-Marquette-Adams County Medical Society include: Brenda K. Jenkin, MD; Sandhya V. Shah, MD; and John E. Walz, MD.

Dane. New physicians approved for membership in the Dane County Medical Society include: Karin Bausenbach, MD; Laura Buyan, MD; Peter Canaday, MD; Michele Coyle, MD; Philip Farrell, MD; Mary Flynn, MD; Tom Herr, MD; Mindy Kim, MD; George Kinzfog, III, MD; Sara Long, MD; Kathryn Middleton, MD; Martha Rolli, MD; Adam Tierney, MD; Harry Velasquez, MD; Sharon Weber, MD; and Simon Wright, MD.

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Dodge. The Dodge County Medical Society approved membership for Bradley A. Allen, MD; Eduardo R. Bermudez, MD; Douglas Earl Bricker, MD; and Steven D. Pals, MD.

Door-Kewaunee. The Door-Kewaunee County Medical Soceity approved membership for Michael S. Bruno, MD; Dorene E. Dempster, MD; and C. Hugh Hickey, Jr., MD.

Douglas. The Douglas County Medical Society approved membership for Stewart J. Hazel, MD; Jean E. Hoyer, MD; Joseph H. Leek, MD; Douglas J. Newman, MD; Clarence M. Scott, MD; Patrick D. Sura, MD; and John S. Yoon, MD.

Fond du Lac. The Fond du Lac County Medical Society approved membership for the following physicians: Curt A. Allison, MD; Thomas M. Ambro, MD; Jaylynn Kao, MD; Michael J. Milstein, MD; Terrance D. Moe, MD; John D. Steiner, MD; and Leonel A. Vasquez, MD.

La Crosse. The following physicians were elected to membership in the La Crosse County Medical Society: Thomas A. Londergan, MD; Michael J. Schaars, MD; and Catherine R. Ryan, MD.

Milwaukee. The following physicians were elected to membership in the Medical Society of Milwaukee County: Brenda L. Banks, MD; Rajesh Bhargava, MD; Brian E. Black, MD; Frank E. Cummins, MD; Ellen S. Danto-Nocton, MD; Thomas Dunigan, MD; Allan C. Edson, DO; Richard M. Fisher, MD; James E. Freije, MD; Mary Catherine A. Gerleman, MD; Lori Ann Heinrich, MD; Sriram S. Iver, MD; Krishna Kumar, MD; Victor Ahmed Maningo, MD; Scott Thomas Moretti, MD; Daniel T. Rapp, MD; Bruce M. Sterman, MD; Lee S. Wann, MD; Norman K. Weinstein, MD; Steven G. Bardfield, MD; Amie Angelita G. Beloy, MD; Russell N. Blankenburg, MD; John F. Bochniak, MD; Thomas R. Brand, MD; William M. Brann, MD; Alicia M. Broeren, MD; Daniel B. Brown, MD; Frederick K. Bulacan, MD; Cynthia Wissel Carr, MD; Joseph H. Chammas, MD; David Hwa-Yuan Chang, MD; Pi-Lin Chang, MD; Karen A. Dana, MD; Marsha F. David, MD; Stephen M. Day, MD; Michael W. DeNardis, MD; Kristina A.Drehobl, MD; Peter Drescher, MD; William H. Dribben, MD; Beth Ann Drolet, MD; Arnavaz Dua, MD; Mitchell R. Erickson, MD; Rebecca L. Freer, MD; Mary Beth Gonyo, MD; Nancy M. Grant, MD; Margarita Guarin, MD; Daniel

W. Guehlstorf, MD; Scott T. Hardin, MD; Matthew S. Harrison, MD; Ron A. Herrmann, MD; Elena J. Holak, MD; Charles W. Horner, MD; James S.J. Hsu, MD; Gregory P. Jackson, MD; Iyad Jamali, MD; Wendi Johnson, MD; Robert H. Jones, Jr., MD; Judith Marie Kisicki, MD; Satish Kodali, MD; Jan M. Laakso, MD; Beth M. Lalande, MD; Michael J. Lasser, MD; Jeffrey P. Lindquist, MD; Henry J. Loomans, MD; David P. Lucke, MD; Gregg M. Menaker, MD; Eric D. Miller, MD; Catherine C. Mingo, MD; David S. Morrissey, MD; Gregory M. Moyer, MD; J.P. Mullooly II, MD; Thomas E. Murtaugh, MD; Denise M. Nachodsky, MD; Jennifer W. Niedfeldt, MD; Gregory Obst, MD; Gregory J. Ostrowski, DO; Colleen J. Reichel, MD; Eric F. Reichman, MD; Christina G. Richards, MD; Rebecca J. Rucka, MD; Sina J. Sabet, MD; Lance E. Sathoff, MD; Brian B. Skaletski, MD; Steven J. Socransky, MD; Kari L. Steffen, MD; Carole C. Street, MD; Michael A. Stutz, MD; Sanjay Bhikhalal Suthar, MD; Wilfred B. Szerenyi, MD; Marcela D. Torres, MD; Sally J. Vetter, MD; Dominique S. Walton, MD; Matthew M. Yeomans, MD; and Daniel I. Zivony, MD.

Ozaukee. The Ozaukee County Medical Society approved membership for Alan E. Reed, MD.

Rock. The Rock County Medical Society approved membership for the following physicians: Mark C. Boettcher, MD; Adalberto R. Castellanos, MD; Leo C. Egbujiobi, MD; Brett D. Goettsch, MD; Perry P. Guaglianone, MD; Mark T. Hartlaub, DO; Joel B. Henry, MD; Douglas R. Johnson, MD; Mary E. McGrath, MD; William R. McIvor, MD; Willette W. Pang, MD; Jonathan Roe, MD; Laurene Spencer, MD; Warren E. Tripp, MD; and Beth J. Yount, MD.

Trempealeau-Jackson-Buffalo. Catherine A. Whitehouse, MD, has been approved for membership in the Trempealeau-Jackson-Buffalo County Medical Society.

Washington. The Washington County Medical Society approved membership for Timothy Teller, MD; Jean Ibric, MD; and Jeffrey Hoffmann, MD.

Waukesha. The Waukesha County Medical Society approved membership for Brian Yudoga, MD; David W. Rogers, MD; Cindi L. Marquette, MD; Kathleen M. Hargarten, MD; Anastasia Hummel, MD; Paul Rehnstrom, DO; Meher Mallick, MD; Jennifer Junnila, MD; Brian Yugoda, MD; and Steven C. Fehr, MD.❖

SMS requests hearing on nurse prescribing rules

THE SMS HAS requested public hearings on Clearinghouse Rule 94-129, relating to independent prescribing authority for advanced practice nurses. The requests were directed to Sen Carol Buettner, who chairs the Senate Committee on Health, Human Services and Aging, and Rep Judy Robson, who chairs the Assembly Committee on Health.

The board of nursing recently forwarded its proposed rule to the Legislature for referral to committee. Upon referral to committee in both the Assembly and Senate, the committee chair has 30 days to review the rules and decide if a public hearing should be held. If a public hearing is held, the committee is given 30 additional days from the date the hearing notice is published to ask the board of nursing to make changes to the rules. A public hearing is expected to be held in at least one committee by the end of November.

At its Oct 8 meeting, the SMS Board of Directors reviewed the proposed rule and expressed concern about several of its provisions, especially the lack of meaningful language on collaboration. In concert with several specialty societies, the SMS will share these concerns with the Legislature and provide the committees with language that will ensure continued high quality health care for Wisconsin residents.❖

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AMA awards

The Wisconsin Physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

* Choucair, Ali Khalil
* Desbiens, Norman Adrien
* Fossen, Richard Fredrick
* Gausas, Anthony Mindaugas
* Gottlieb, Viktor
* Gross, Jody Roselyn
Haselby, Ray Cloyne
* Holt, James Jos.
* Hunt, Vernon Brock
* Idarraga, Samuel
* Jennings, Richard Paul
* Kangayappan, Sivakami
* Kase, Evelyn Claire
* Krall, Edward Jos.
* Peterson, Douglas Wayne
* Pfefferkorn, Ethan Dolf
* Reding, Douglas James
Rhoades, Bruce Cecil
* Rothfusz, Ronald Ray
Rupp, George Mac Donald
* Schumaker, Howard Dale
Sell, Patricia Ann
Springer, Joseph David
* Stafl, Jaroslava
* Steward, William Arnold
* Stueland, Dean Theodore
* Thomas, Jonathan Wesley
* Wadhwani, Indur Bhojraj
* Wegehaupt, Paul Karl
* Weisenthal, Chas. Leonard
* Wertsch, Paul Anthony
* Wineman, Bruce A.
* Zoch, Thomas Wm.

September 1994
* Richard L. Cooley
* Ian L. Goldman
* Henry I. Grant
* Mark A. Huffman
* Carol J. Neuman
* Muni H. Patel
* Carl R. Poley
* Joseph V. Richards
* Lawrence K. Siegel
* John M. Williams
* Raymond W. Witt❖

Making the most of your charitable giving through the PIC-Wisconsin matching grant program

THIS FALL, the PIC Wisconsin Board of Directors established a matching grant program for physician contributions made to the SMS-CESF Medical Outcomes Research Project (see, *WMJ*, August 1994). For every physician dollar given to the Project, PIC will contribute two dollars for the project's operation--effectively tripling the contribution. Physician contributions are defined to include individual physician gifts, gifts from medical practices and clinics, county medical societies, specialty sections and other physician organizations.

To support the SMS-CESF Medical Outcomes Research effort, PIC created the matching grant program in conjunction with an endowment fund that will begin in 1995. This grant helps to augment the project grant approved by the SMS Board of Directors at its Oct 8 meeting that will fund around half of the projected costs for 1995. The CESF Medical Quality Research Council is preparing for the next project phase, collecting medical outcomes data beginning in January 1995.

Gifts made to the CESF Medical Outcomes Research Project qualify as charitable contributions to a 501(c)(3) organization and are tax deductible. (Contributors may not claim the matching portion of the gift given by PIC.) For more information about the matching grant program or if you would like to make a contribution, please call or write Julie A. Hein, CESF Managing Director, PO Box 1109, Madison, WI 53701; 1-800-362-9080 or, in the Madison area, (608) 257-6781.❖

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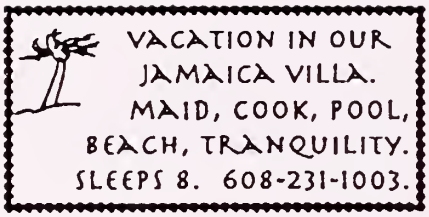

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COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

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Peppino's Restaurant 572
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Trustmark Insurance Company 584
Proservices 577
U.S. Air Force 575
Waukesha Memorial Hospital 604
Wisconsin Back Society 567
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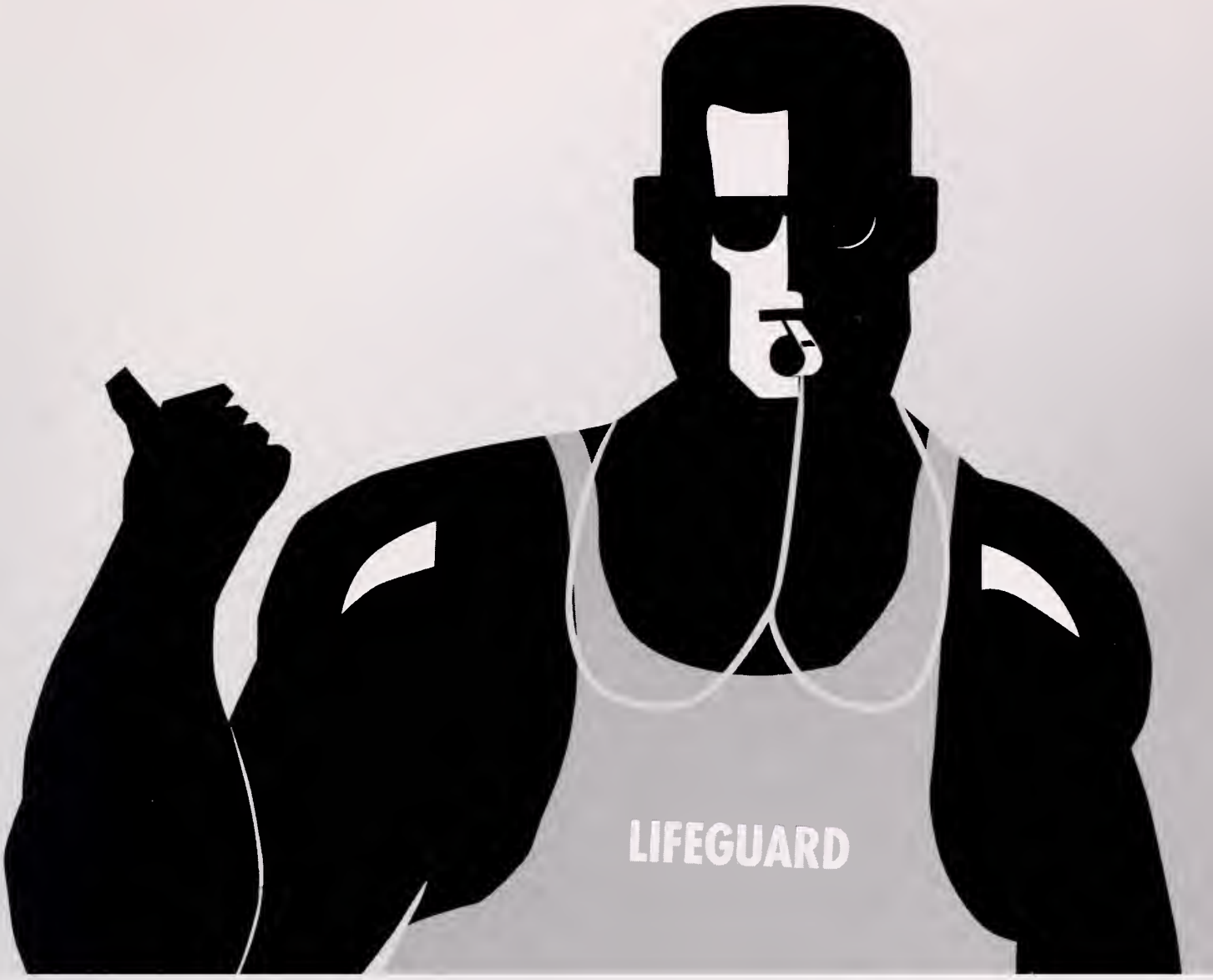

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Contents

December 1994 Vol. 93 No. 12

Opinions

613 *President's page*
A New Year's resolution for the new era's revolution: Leading change through a changing lead
by Richard G. Roberts, MD, JD, Madison

616 *EVP report: The view from here*
At the heart of medicine lies the heart of humanity
by Thomas L. Adams, CAE, Madison

617 *Letters*
The costs of poor choices
by William A. Schultz, Madison

618 *Soundings*
Class reunion
by Tom Moskalewicz, MD, Appleton

Scientific

621 AIDS: Sonography of hyperechoic renal pyramids in renal candidiasis
by John R. Sty, MD; Robert G. Wells, MD; and Robert C. Hardie, MD, Milwaukee

623 Screening men for domestic violence in your medical practice
by Mark Chelmowski, MD, and L. Kevin Hamberger, PhD, Milwaukee

627 Health education delivery by Wisconsin veterinarians
by Douglas J. Reding, MD; Virginia Fischer, MS; Karen Lappe, RN, BSN; and Paul Gunderson, PhD, Marshfield

Socioeconomic

631 Stark realities: Coping with federal and state self-referral paranoia
by Alyce C. Katayama, JD, and Lisa A. Lyons, JD, Milwaukee

636 *Public health*
Epidemiology of osteoarthritis
by David L. Nordstrom, MS, Marshfield

639 PIC Wisconsin: Continued commitment to physicians
by Richard W. Edwards, MD, Richland Center

640 Medical facilities must report information about induced abortions to state

Organizational

641 Mini internship report: Creating new and stronger allies
by Shari Hamilton, assistant editor

645 CES Foundation awards two research grants

646 Teen Workshop on Health brings safety message to Wisconsin kids

647 Physician briefs

647 Annual meeting resolutions due

649 County society news

650 Obituaries

652 AMA awards

653 Index to articles: 1994

Our cover: Shari Hamilton, assistant editor of the *WMJ*, observes as Ivan Teoh, MD, skillfully performs an appendectomy. Hamilton participated in the recent mini-internship program in Ashland--her story beings on page 641. (Copyright photo by Bob Rashid.)

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The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles; it does not screen socioeconomic or organizational articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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President's page

A New Year's resolution for the new era's revolution: Leading change through a changing lead

A NEW ERA... The Republican revolution... A Contract with America... The US Congress and Wisconsin Legislature are under new management and the rules, although perhaps not the game, have changed. Change in government is followed usually by change in the economy as the marketplace responds to new incentives. What all of this means for physicians and patients remains to be determined.

Shifting federal and state priorities draw attention to the debate in our capitols and can obscure the reality that all politics is local. We are most affected by what happens in our communities, not in Washington or Madison. The challenges of crime in our cities, social and economic justice in our towns and the future of our families depend on the safety of our streets, the success of our local businesses and the security of our schools and homes. Similarly, the local economy and practice environment will remain the most important determinants of physician and patient satisfaction with the local health care delivery system.

Richard G. Roberts, MD, JD

Regain to retain

Physicians can retain the ability to shape our practice environment if we regain our roles as influence leaders on matters of community health. The demands of our daily responsibilities have limited out ability to step forward to lead our communities as *physicians*. The rigors of patient care and health system management increasingly isolate us to our offices and hospitals. We must discover models for involvement that permit us to balance successfully our daily demands with our desire to help our communities. The experiences with CHILD SAFE provides an example of such a model.

The lessons of CHILD SAFE

The fundamental lesson to be learned from CHILD SAFE is that success

Continued on next page

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has depended on the support and help of a number of other organizations. The desire of physicians to be community influence leaders and the demands of a busy medical practice can be reconciled only by building coalitions with others. Local medical societies and their communities have each developed unique approaches for successful CHILD SAFE coalitions; yet common themes can be found in all the local projects.

The county medical society must first decide which activities it would like to take on as it creates its local CHILD SAFE project. Once the activities are decided, then appropriate groups or organizations should be contacted. The next step is to contact and excite the group about participation in CHILD SAFE. The more personalized the contact, the more likely the prospective partner will agree to participate: a visit is more persuasive than a phone call, which is preferred to a letter. Generating enthusiasm for the project goes a long way to obtaining commitment to help. Throughout the planning and managing of the event, lines of communications must be open so that roles are defined clearly and, as necessary, renegotiated; performance is assured; and praise is bestowed.

A recent example of a successful CHILD SAFE partnership involved a public awareness project on gun violence and children in the form of an event where free trigger locks were distributed through a drawing at a shopping mall. The chief of police was contacted and expressed interest in the project. The chief was invited to a meeting where the various approaches were discussed. The early support of the police proved helpful in recruiting other lawenforcement agencies in the county to support the project and volunteer during the drawing. A date was set for the drawing and volunteers were identified to staff the booth at the mall. Medical society members, law enforcement volunteers and Alliance members all helped staff the booth. Promotion of the event was conducted before, during, and after the event through medical coverage.

Steps to success

Commit to action. Your local medical society must decide to take on the project and which partners it would like to have participate.

Commit others to action, too. The most frequent reason given by people for not contributing is that they were never asked. Your request for help will be difficult for others to resist if you focus on their interests (eg, "Your organization's participation--or money, or support--will make for an even bigger and better event, which will reflect well on you in the following ways..."). If you can't get a commitment for volunteers, then ask for money; if they won't give money, then ask for support or an endorsement. Examples of groups to approach include:

- Business--chambers of commerce, farm groups, Jaycees, professional associations, unions;
- Civic--League of Women Voters, parent-teacher organizations, public safety (EMS, fire, police), school boards;
- Fraternal--Elks, Lions, Kiwanis, Optimists, Rotary; and
- Special--AARP, Gray panthers, hunting groups, political parties, religious groups, social clubs.

Shared responsibility means shared ownership. A greater level of commitment results when others feel like they had a hand in creating the project. Encourage other groups to share their concerns and creativity, in addition to their time, dollars and support.

Plan the work and work the plan. Successful events and projects are rarely accidental or spontaneous. They require considerable planning and implementation. Once a plan has been decided, follow through on it. While some flexibility is necessary to respond to changing circumstances ("It would be great if this group, which just showed up at today's event, could also help."), resist last-minute temptations.

Praise publicly and profusely. You can never give too many awards. Recognize publicly the valuable contributions made by others. Find opportunities to thank those who help you (eg, an award at the annual meeting of the medical society).

Acknowledgements

My thanks to Maureen O'Brien for her example and ideas on coalition building, to the SMS staff members who comprise the President's Team --Kathy Andersen, Shari Hamilton, Jim Hoegemeier, Noreen Krueger, Don Lord, Cheryl McCollum, Maureen O'Brien, Lynn Sherman, and Steve Whittow--and to the many physicians, local medical societies, and communities who have answered the call and made CHILD SAFE a success. ❖

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EVP report: The view from here
At the heart of medicine lies the heart of humanity

ONE MORNING LAST MONTH, I had one ear on the morning news as I tried to get my daughter Ashley ready for another day in first grade when I heard a story that made me stop. ABC's *Good Morning America* was interviewing Billy Best, the youth who ran away from home because he could no longer tolerate the painful treatments for his disease. I felt for his parents, because I know how I would fight for the lives of my children, but I also felt for him, because I don't know how many of us have what it takes to endure a slow, painful life-and-death struggle.

Thomas L. Adams, CAE

The next day, the same program interviewed a young woman, Lacy Strickland, who was facing a similar ordeal with a similar ailment--but with a difference. Rather than letting her pain, her fear, and her grim prognosis drive her into hopelessness and despair, she responded with remarkable courage, strength and optimism. In her hour of darkness, she became a beacon of light to guide others.

As I thought about these contrasting reactions to similar conditions, a number of half-forgotten truths resurfaced into conscious thought. Like how important attitude is to healing and how physicians must be sensitive to the widely divergent feelings their patients are able, and likely, to have. And how the difference between fulfilled and unfulfilled lives is so often determined by attitude, by how different people interpret and react to the same circumstances.

When I reached the office and started dealing with Medical Society issues, the reactions of Billy and Lacy came to mind again. In the medical bureaucrats' rush to cut health care spending with practice protocols, they must remember that medicine is a human endeavor. They must not forget that every patient, and every patient-physician encounter, is unique. Different bodies react differently to the same pathogens, medications, injuries, and treatments. Each patient is an almost infinitely complex, ever-changing mix of variables that can affect their health or their reaction to medical treatments. And those variables range from the genetic codes passed to them by their ancestors to what they had for breakfast this morning.

The art of medicine begins when the physician reads beyond the basic vital signs and into the subtleties of a patient's symptoms and complaints, into the nuances of the patient's medical history, into the murky shades of meaning within the intricate, often enigmatic, human picture at the far end of the stethoscope. Only human beings can perceive and comprehend human beings, but more importantly only humans can genuinely care for humans.

All of which made the issue I was dealing with that morning--explaining to business people the development of practice parameters and other protocols--seem particularly difficult.

Wisconsin has been at the forefront of developing responsible managed care systems, and we've worked hard to do it right. Not to suggest that our's is a perfect system, but Wisconsin has been effective in spending wisely, creating mechanisms for prudent quality review, involving physicians in the design and implementation of the system, and in providing the best care modern medicine has to offer. That our costs are among the lowest and our health is among the best in the nation speaks volumes about what we are accomplishing. But there are many parts of the nation where our model is not being followed, and there is reason for concern.

We must be certain that our new managed care systems retain respect

for the patient and room for caring. We must resist the push by health insurers, large employers, health administrators, and government regulators to reduce health care to something simple, quick, and clean. Without the influence of medical doctors, this activity has the potential to reduce health care to the exchange of a product or service for money, stripping it of its genius, its art, and itshumanity.

I encountered this attitude recently when I was involved in a statewide forum on the evolving health care system. For a couple of hours, I sat and listened to several forum participants continually refer to doctors as "providers." Finally, I could take no more. "Excuse me," I said, "but the professionals of whom we are speaking are not providers, they are *physicians*." I then did my best to remind the crowd that healing the ill and injured is not the same activity as providing goods and services. Medicine is more than pills and sutures. Diagnosing a disease is not just a fancy form of checking under the hood. Treating a disease is not a high tech version of selling widgets. After a few minutes, I saw some heads nodding, which gave me cause to believe I was heard.

As we move toward the next stage of evolution for American health care, it will be important for everyone to remember that warmth, artistry, and humanity are crucial components in caring for each other. The need for attentive, skilled physicians to truly see and know their patients will not change. We must be certain that the evolving system of delivering that care is capable of distinguishing between patients like Billy Best and Lucy Strickland.❖

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The costs of poor choices

To the editor: Congratulations on your excellent article in the October WMJ regarding the impact of lifestyle choices on the cost of health care. I have always felt strongly that this is where health care "reform" should be focused. Education and incentives for making better choices will have a more positive, longer lasting societal impact than will mandated coverage.

—William A. Schultz
Madison

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Soundings
Class reunion

Tom Moskalewicz, MD, Appleton

I TRUDGED DOWN THE front path in a March drizzle, nearing the end of a long, hectic day. I stopped on the porch, opened the mailbox and withdrew a long envelope bearing the insignia of alumni relations. Then I shambled bleary-eyed and world weary into the foyer, where I stopped again, and read the news about our 15-year reunion. Brighter lights and familiar voices welcomed me home, as I lingered over the details: there in a column on page two, my name was among those who had fallen so far out of touch, that they were listed as missing.

Fifteen years had proven to be both a long time and a long distance. The time had slipped away, evaporated, since that rainy June night in Chicago when we stood under the glittering ballroom candleabra on the same platform and together took the Hippocratic Oath. Fifteen years was also now the distance by which most of us had long-ago surrendered any meaningful contact with one another's lives.

Strong friendships had been forged during that difficult trial-by-fire we still refer to as simply "med school." The mid-'70s had brought steady contact: in basic science lectures and cadaver lab; in libraries and hospitals; at the bedside learning about "patient care," listening to our tutors, observing the critical actions and tough decision-making of our elders.

We lived and worked and studied in a confused culture back then: the plastic-coated guilt-ridden context that marked the end of the Vietnam War and mixed-in disco-era polyester. We submerged ourselves in medicine. Internship year began barraging us with its sleep-cheated responsibility-pressurized apprenticeship. We were swept up and swept along by a current of rigors and challenges and demands we could not control. Year by year, we hiked the rocky trails of a physicians life, and those graduation night promises to keep in touch had fallen apart. Fifteen years had dulled it all into an anecdotal romanticized fog of remembering.

Now, medicine siphoned off most of our time and energies, and our families owned the rights to whatever was left over. Now,the old friendships had been reduced to the sporadic Christmas card, complete with updated smiling family photo and handscrawled notes that tried to condense years of living into a few uneven sentences. Notes that tried to avoid the truth of what we had become to one another: mostly a collective mystery; a mystery complicated by the myths we still protected.

* * *

The journey back lapped the miles toward Chicago. The dull gray tracking of the roadway dulled the brain: Its hypnotic sweeping-by rush of white and yellow lines made the atmosphere ripe for daydreaming. I traveled back barefoot and whistling into those wildflower pastures, where images of a younger time and self still thrived.

I fashioned a personal list of the classmates I would most like to see again. Phil, the stand-up comic and skilled impersonator. Bennett, sharing his fluent all-things-work-together-for-good perspectives. And Stray, the back-alley philosopher, fond of scotch, quoting Marcus Aurelius, and closing the after-test party with a 3 AM Zorba-the-Greek circle dance. And Gwen, sashaying down hospital corridors in a short white coat, stethescope curled around the smooth neck. I heard again her blunt and sassy comebacks, and her witty style of disarming attack by cutting straight-at the truth.

Chicago's blank skyscraper stare moved closer. And through the smokey air, from his1975 album *Blood On The Tracks*, Dylan's gravelly voice sang to memory: "She might think that I've forgotten her; tell her it isn't so-"

* * *

I was among the first few to arrive. I stood in the potted fern and figtree courtyard of a fine Chicago restaurant. I sipped from a green longnecked bottle and scanned the area for any sign of a familiar face.

Slowly, they appeared. A series of handshakes and hugs and long-time-no-see! greetings broke out all around me. Brief conversations came gattlegunned into my senses: Don, our class president who had lost most of his once shaggy shoulder-length hair; and Dave, our class valedictorian, who paused to introduce his wife, to ask where I now lived, and what kind of medicine was I practicing. Joanne, who lent me her lecture notes when my own were destroyed in a dormitory fire, bestowed a brief hug, then pulled back and introduced me to her firm-grip husband. She showed me pictures of her home in Cleveland and of her three children. I finished my second drink discussing health care reform with Paul, who now practices neurology in Vermont.

Our short clips of conversation fenced a distant past. We kept most of the reunion talk safe—skimming

across the scattered memories of the medical education we had once shared.

We grouped for dinner at large circular tables, and then I felt a slap across my shoulder and turned into a grinning face. Stray had a shorter haircut and a deep California tan, and my eyes had to reconnoiter a few seconds before I recognized him. He saw the confusion in my eyes, and squeezed the handshake longer. "Its me, old friend! Tell me I haven't changed *that* much..." As we ate our salads, Stray told me about the insecurities and the bitter aftershocks of his recent divorce.

I told him he was the only one of my "top 7 preferred" list who had showed; he asked me, "Who else was on your list?"

"Phil and Bennett," I replied. "And Gwen." He frowned.

"Didn't y-hear? Gwen's dead."

My gut's reflex was denial—"No!" Then I held his gaze, and groped for a different answer. "Are you sure?"

"Killed in a car accident last year, is what I heard."

Gwen's younger image hurried back to me right then—a balm trying to soothe suddenly inflicted wounds. It was June of 1975—only a few minutes after the last #2 -lead-pencil-circle-answer of the big test hurdle—Part I of national boards. Gwen appeared in the alleyway that led back to Stray's "courtyard"—the ambience of uneven cracked cement, sagging back porch, and streetlamp that served as the arena for his parties. She was wearing a thin-strapped sunflower-yellow dress, and she moved breezily toward us—waving in her right hand Dylan's newly released album, *Blood On The Tracks*. Her left hand carried a quart of Jack Daniels by the neck. I saw again, in the moments after hearing of her death, the full blush of the sun on her upturned face. I studied the thin red lines of her parting lips and the wincing expression as her tongue tasted the squished section of lime, then quickly swigged a shot.

* * *

Don and Dave supplied brief after-dinner speeches that romanticized our collective past. Then suddenly it was over.

We parted ways with more handshakes, hugs, and the same keep-in-touch promises that we had broken over the course of the previous 15 years.

Only two cabloads of classmates chose to extend the reunion a few more hours. We scrunched close together and traveled a short distance to a local dance club. We moved past the glare of a burly bouncer, ducked through a low doorway and into a large room that clamored

continued on next page

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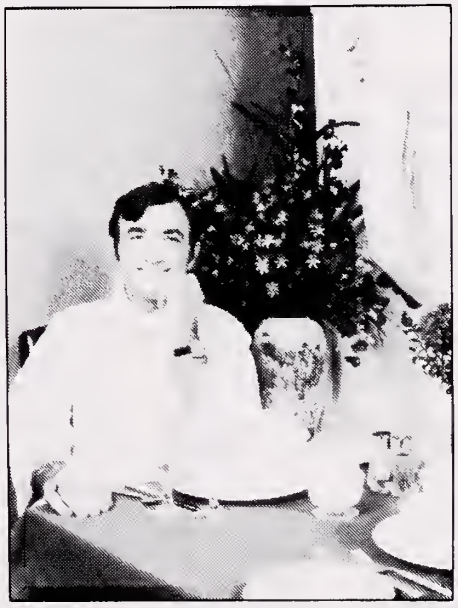

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shoulder-to-shoulder with swaying and sweating forms. Drums pounded rhythms into our brains.

Stray danced with a series of limber women who payed him no heed once the rhythms of the songs were spent. Then suddenly he stood among us, balancing a tray of shotglasses full of jiggling, pale brown liquid. "Jack," he explained. "To toast Gwen. I figured the last thing she'd want us doing is acting gloomy in her absence."

The tray passed in a slow circle, until the hands of her classmates held a small glass, trying to steady it close, waiting. Speaking in a clear voice above the murmuring din of the crowd, Stray raised his glass: "To a colleague who was truly unique. And one who once turned me on to listening to the lyrics of Dylan. May she stay—in our memories—forever young."

I swallowed hard. Then I chased the shot with a wincing jolt of memory's limejuice.

I recalled another dance, another farewell. One of the orchestra's last songs—turning slowly with Gwen, on graduation night, a backless-dressed spin in my not-wanting-to-let-go arms.

I had whispered, close against her ear, so that she could feel the unguarded warmth of my breath--"My only regret is that I never dared / to test the territory / beyond friendship." We were telling parting secrets, and it sputtered out in three parts.

She caught my gaze and held it. She searched for sincerity and its intentions. Then her smile turned curious and wispy—until it had captured the reply that was lost to words.

"You never asked," is all she said. Then she buried her warm face into the crevices of my neck and shoulder. We held close and spun through the final notes of the song. It was music full of some urgency, insisting that the time had come to say goodbye.

We waited outside the hotel for cabs that would take us in different directions. There she added, "Maybe we should fly somewhere far away together." It became last-minute negotiations to risk one of internship's vacation weeks on the process of reconnecting, of undoing our goodbye.

Which is why memories of Haiti rattled my core, in the aftershocks of Stray's Dylan toast. Four months later we fled from our tiring barrages of an intern's responsibilities and converged, late afternoon, on Miami's International Airport. Then we boarded the evening flight into Port au Prince, where the soldier in customs cracked open her suitcase and rumaged through silky undergarments and lingerie, and the cab driver who shuttled us up the hills to our wide-veranda hotel, assumed we were man and wife. Within the hour we were making love as a hard tropical rainstorm pummeled the roof above us. We woke to small green lizards scurrying across the ceiling.

We swam in a windswept ocean. We gambled blackjack in an all-night casino, where the dealers spoke spanish and creole. We roamed the dusty crowded streets, full of the listless stares of the downtrodden poor. We stopped inside a broken-down cathedral and knelt to pray. The next night, a young Haitian guide led us out into the dark countryside, where we sat around a crackling fire. There the rhythms of the drums and the frenzied footsteps swept us into a voodoo ceremony.

The next day we flew north to Cape Haitien. We bargained for burros and guides at the base of the mountain, then climbed first past the Queen's Palace, then along a steep-narrow winding jungle path. At the summit, we sat on the Citadel's thick walls and ate soggy, stale-sandwiches.

Our last day on the island, we drank rum from late morning until far past darkness, and several times more we tore down every defense and yielded to the naked truth of one another.

Which is why memory seared of Haiti when I heard of your sudden death. The taste of Jack Daniels came coupled to a distant, primitive connection. You lived again inside my private moments. And jungle drums lit fires—across the rugged lost continent of my soul.❖

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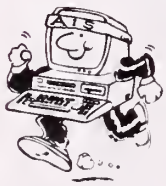

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AIDS: Sonography of hyperechoic renal pyramids in renal candidiasis

John R. Sty, MD; Robert G. Wells, MD; and Robert C. Hardie, MD, Milwaukee

A 13-month-old patient with autoimmune deficiency syndrome had renal candidiasis. An abnormal renal sonographic pattern of hyperechoic renal pyramids was demonstrated. This abnormal sonographic finding should suggest renal candidasis in an immune suppressed child. In the normal kidney of children, the pyramids are hypoechoic. This pattern has not been noted in previous publications. We report a case. *Wis Med J.1994;93(12):621-622.*

Candida is a saprophytic fungus of humans. Under certain predisposing conditions, the organism can become pathogenic. Infection by Candida can manifest itself as either local or disseminated disease.

Patients with indwelling catheters, hyperalimentation, immunodeficient states, prolonged antibiotic or immunosuppressive therapy and premature infants with decreased immunity are particularly susceptible to Candida albicans infection. Ultrasonographic findings with renal involvement have been reported.[1,2] We report an uncommon sonographic finding of hyperechoic renal pyramids in an AIDS patient with renal candidiasis.

Dr Sty, Dr Wells, and Dr Hardie are with the Children's Hospital of Wisconsin. Reprint requests to: John R. Sty, MD, Children's Hospital of Wisconsin, 9000 W Wisconsin Ave, #721, Milwaukee, WI 53226. Copyright 1994 by the State Medical Society of Wisconsin.

Case report

This 13-month-old boy had a fever with dehydration, vomiting and acidosis. The diagnosis of AIDS was made 4 months prior to this admission to the hospital. The patient had not previously been treated for prior serious infections and had been doing well. A chest radiograph showed nothing abnormal. Results an analysis of the cerebral spinal fluid were normal. Urine analysis demonstrated Candida albicans. Sonography of the abdomen showed a normal liver and spleen. The kidneys were slightly enlarged and had hyperechoic renal pyramids. The renal cortex was normal, there was no evidence of debris within the collecting system (Figure), and, likewise, there was no evidence of obstructive uropathy. The renal pyramids are usually hypoechoic in the normal kidney and less echo-filled than the cortex.

Discussion

Infection by Candida albicans can be grouped into two categories: superficial and deep (systemic). The superficial forms of infection tend to be self limited, requiring little in the way of therapeutic intervention. The systemic form of the disease has a high associated morbidity and mortality. The mainstay drugs for treatment of this disease remain amphotericin B and flucytosine. The potential toxicity of these regimens is well known.

The differentiation between the systemic and local forms of disease can often be difficult. The finding of yeast in hyphal forms in the urine is nonspecific. It may represent: a contaminant, a local infection due to Candida cystitis, or a systemic infection. In a study of 109 children with disseminated candidiasis, Hughes[3] found that renal and hepatic function tests were normal in half the patients with candidiasis of these organs. Consequently, imaging studies are important in the differential diagnosis.

There is a marked propensity for deep organ Candida infection to involve the kidney. In an autopsy series of disseminated candidiasis conducted by Parker et al,[4] a characteristic pattern of deep organ involvement was noted. In their se-

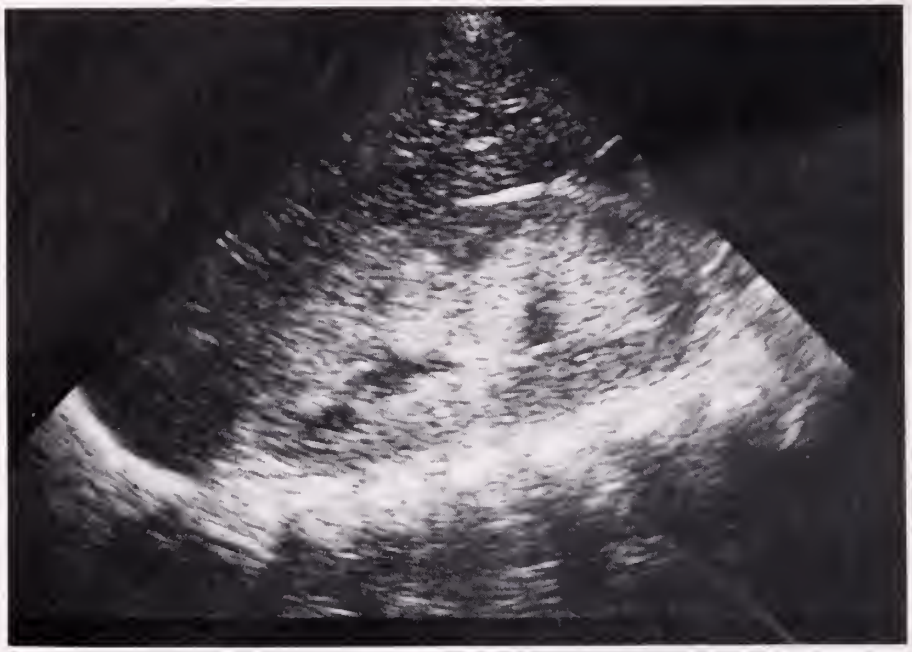

Fig.--Longitudinal image of the right kidney. The image shows no evidence of hydronephrosis. The medullary rays are hyperechoic. There is no evidence of perineural disease.

ries, 80% had genitourinary tract involvement, and half had CNS involvement.

Pathologically, the initial lesions of renal Candida infection are microabscesses with inflammatory cells in the parenchyma. Later complications include mycelia collections in tubules, necrotizing papillitis, and fungus balls in the pyelocalyceal system resulting in hydronephrosis. The two reported sonographic patterns in candidiasis are a pyonephrosis with an echo-filled, dilated collecting system, or a diffusely increased echogenic kidney. Intra- and juxtarenal abscesses will also be associated at times with these findings. The fungus balls typically appear as echogenic masses without acoustic shadowing. In our case of renal candidiasis, the sonographic pattern was somewhat different. The examination showed very echogenic renal pyramids with a normal cortex. Although other forms of imaging can be used, sonography remains the mainstay because of ready availability and high accuracy. This examination does not need contrast administration as does computed tomography. Contrast administration may be contraindicated if renal function is compromised.

The difference in ultrasound patterns with Candida albicans infection of the kidney are most likely due to the pathophysiology and stage of evolution. Our case most likely represented the form of disease where mycelia collections in the tubules and papillitis are the predominate manifestations. Increased areas of abnormal echogenicity have also been identified in bacterial infections which have resulted in dilated cell filled tubules. The differential diagnosis of increased echogenicity in the renal pyramids needs to include Candida albicans infection as a diagnostic possibility. Increased echogenicity with other disease processes can be focal or diffuse, with or without acoustic shadowing. The medullary type of increased echogenicity is more frequent than the cortical type. Theses entities include primary hyperparathyroidism, renal tubular acidosis, primary oxaluria. Parenchymal renal disease includes chronic glomerulonephritis, medullary sponge kidney, and various vascular conditions.[5] These diseases have a much different clinical presentation than renal infection with Candida. Consequently, renal sonography showing this particular pattern is extremely helpful in the differential diagnosis of superficial and systemic Candidia albicans renal infection in a patient with AIDS.

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Screening men for domestic violence in your medical practice

Mark Chelmowski, MD, and L. Kevin Hamberger, PhD, Milwaukee

THE OVERWHELMING majority of victims of domestic violence are women, with the batterers being men.[1] Each year, 2 million to 4 million women in the United States are victims of domestic violence, making battering the leading cause of injury to women.[2] Among all women seeking care in an ambulatory clinic, up to 40% report a history of being battered by an intimate partner.[3] Further, children of these women are also at risk for being abused[4] and developing a number of behavioral and psychosocial problems.[5] Early identification and appropriate referral of battered women can help prevent future harm to these women and their children.

Although sheltering battered women and children is crucial for ensuring immediate safety and crisis intervention needs, a view shared by many working in the field of domestic violence is that, to ultimately decrease violence against women, the causes of their physical and psychological harm need to be addressed.[6] These causes include distal, or social and cultural factors, as well as proximal, or immediate factors.[7] The most salient immediate cause of woman abuse is the male partner who is battering.

Although incidence and prevalence studies have not been conducted, it is reasonable to assume that, like battered women, men who batter also seek routine health care in ambulatory settings.

Identification of batterers can occur by self-report, after victim report (case finding), or upon directed questioning by the health care worker (screening). Identified batterers can be counseled about their responsibility for the violence and their need for change. They can also be offered treatment that may help them change their behavior and provide safety for their partners and children.

Case report

A 34-year-old married man was seen for a routine physical examination. He was a recovering alcoholic who regularly attended Alcoholics Anonymous meetings for several years. He had a severe cerebral contusion from a serious motorcycle accident 5 years prior that left him comatose for several days. He recovered without any obvious sequelae. A follow-up CT scan of his head was normal. He returned to his job in management several weeks later.

On completion of the examination, his physician paused to write notes and the patient volunteered, "You know, Doc, since my accident I have had a hard time controlling my temper." When asked what he meant by that, he said, "Things just get to me more than they used to before the accident; my fuse is shorter." When asked to elaborate, he said, "Well, I do not have any patience anymore at work or at home and sometimes I feel myself taking out my frustration on my wife." He was asked directly if he ever hit her, and he responded that he struck her on a number of occasions with his fists, and once his wife sought emergency room treatment for serious bruises that he had inflicted.

His physician's response consisted of several key components. The first component was supportive confrontation. He reassured the patient that after a serious injury such as his, feelings of anger and frustration are not unusual, but that this type of behavior was probably not caused by his injury. It was stressed that his violent behavior was not an acceptable way to cope with his feelings. Second, the patient was encouraged to accept a referral to a local program for men who batter their partners. Third, he was also encouraged to control violent urges by physically leavingthe situation when he began to notice his anger levels rise. While gone, he was instructed to use a relaxation technique and remind himself to avoid using violence.

Discussion

Knowledge of community resources for victims as well as abusive partners is crucial. Many communities have organized treatment programs for men who batter (Table).

Men who batter also seek medical care in ambulatory care settings for routine health needs. As with battered women, when a man is identified as a batterer, one important intervention is to provide him with appropriate patient education and referral information. Other in-office interventions with batterers and their partners include supportive confrontation and control planning and safety planning with the victim. These principles are illustrated in the following case report.

It is uncommon for a batterer to volunteer information about violent

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behavior to a physician and, unlike the patient in the case report, batterers are often unwilling to admit or take responsibility for their actions. Generally, a batterer is identified after the victim reports an incident of abuse.

Psychological or physical abuse is generally used to exert power and control over another individual in a relationship. This behavior may be learned as children. Boys who witness abuse as a child are at increased risk to behave abusively as an adult.[8] Batterers are more likely to lack assertive communication skills and have difficulty negotiating conflict.[9] Psychological testing has shown batterers to have a higher incidence of borderline, passive aggressive, antisocial and narcissistic personality disorders.[10]

Batterers are more likely to have a criminal record and to have committed other episodes of nonspousal violence.[11] Alcohol and other substance abuse is also more prevalent in batterers.[8] In these cases, chemical dependency treatment should supplement batterer treatment.

It is unclear whether biologic factors play a significant role in the genesis of violent behavior. One study has suggested that individuals who have a history of repeated head injuries may be more likely to engage in violent behavior.[12] Furthermore, Rosenbaum et al,[13] in a controlled study, found that history of significant head injury produced a sixfold increase in the risk of marital aggression. A subsequent study by the latter group[14] assessing marital violence among head-injured males, however, did not find increased risk in comparison to a group of orthopedically injured men. The role of head injury in the genesis of marital violence remains unsettled.

Similarly, compared to nonviolent men, batterers show a number of differences on measures of personality, psychopathology, and criminal behavior, although these variables are not universally pathognomonic. There is no typical batterer profile. This problem can and does occur in all socioeconomic classes, and many men who batter show no evidence of psychological distress or criminal lifestyle.

The tone of inquiry when asking about violent behavior should not be overly confrontational or sympathetic. Rather, a matter-of-fact, problem-solving approach which encourages collaboration with the patient is likely to yield more information and greater cooperation. Asking about abusive behavior using the "funneling technique" begins with broad questions like "How is your relationship with your significant other?" and is followed with further questions, such as "We all argue. What happens when you and your partner fight?" If screening questions reveal possible violent and controlling behavior, more specific questions concerning hitting, shoving, pushing and the use of weapons and threats should ensue. The physician should not attempt to mediate disputes between partners. Couples counseling can actually lead to increased violent behavior and should not be suggested until the man has stopped his battering.

If the threat of more violence appears high, the physician should consider notifying the partner of a batterer to discuss safety planning and community resources. If the threat of violence is not imminent, and the woman is already a patient in the practice, discussion about battering and safety planning could be undertaken at a future visit. If the partner is currently not under the physician's medical care, the physician could ask the batterer for permission to contact the victim separately. Such a request of the man could be framed as part of the standard operating procedure, for example: "In cases such as this, I have a policy of contacting the woman and inviting her in for a consultation. This way, I can find out her perspective on things, and answer any questions she may have." Such contacts with the battered spouse, however, must be confidential from the abuser. Unauthorized disclosure to an abuser of information provided by a battered woman can further endanger her.

If a patient discloses that he has assaulted his partner, there is no legal duty to report the offense to authorities, but there are circumstances which could warrant reporting or other efforts to warn or protect potential victims. For example: If, upon further assessment, it is suspected that children are also being abused or maltreated, this must be reported to child protective services. Alternatively, if a patient discloses specific plans and intent to harm or kill another, the health care provider assumes responsibility to warn and protect the potential victim.[15] Such responsibility could include hospitalizing the assaultive patient, contacting the potential victim and others who could assist in preventing assault or homicide from occurring.

Specialized counseling programs for spouse abusers have developed in recent years. A typical program, such as that conducted by the second author in Kenosha, Wisconsin, consists of 15 to 24 weekly small group sessions. The primary goal of the counseling is for participants to stop physical, sexual and psychological abuse of their partners. Sessions emphasize the participants' responsibility to stop the violence and control their own behaviors and feelings. Equality and sharing of power between partners is stressed through training in responsible assertive communication and conflict resolution skills. Relaxation and self-imposed time-out skills are taught to facilitate self-control of physical and emotional arousal. Participants also learn effective problem-solving skills for thinking about and choosing alternative courses of action in difficult life circumstances.

Research on treatment programs shows that 50% to 75% of men who

Domestic violence programs in Wisconsin, 1994.

Beaver Dam
Lutheran Social Services
1010 DeClark St
Beaver Dam, WI 53916
Contact: Joanne Damico-Grajczyk
414-887-3171

Eau Claire
NOWS
202 Graham Ave
Eau Claire, WI 54701
Contact: Charles Rumberg
715-832-3471

Fond du Lac
Men's Group
Friends Aware of Violent Relationships
PO Box 1752
Fond du Lac, WI 54936-1752
Contact: Marilyn Pape
414-922-7760

Green Bay
Alternatives Program
1725 Dousman St
Green Bay, WI 54307
Contact: Cindy Wilkinson
414-498-9182

Catholic Diocese of Green Bay
1825 Riverside Dr
Green Bay, WI 54301
Contact: Cecelia Held
414-437-7531

Janesville
Deferred Prosecution
Domestic Violence Intervention
51 S Main St
Janesville, WI 53545
Contact: Kris Koeffler
608-757-5677

Kenosha
InterConnections
920 6Oth St
Kenosha, WI 53140
Contact: Theresa Potente
414-654-5333

Program for Men Who Batter
PO Box 598
Kenosha, WI 53141
Contact: Kevin Hamberger
414-553-9500

Lac du Flambeau
Lac du Flambeau Domestic Abuse Program
Box 67
Lac du Flambeau, WI 54538
Contact: Sue Wolfe 715-588-7660
(Main # 588-3371)

Native American Statewide Shelter
1-800-236-7660

La Crosse
Men's Abuse Program
Family and Children Center
2507 Weston St
La Crosse, WI 54601
Contact: Ingrid Peterson
608-785-0001

Madison
Program to Prevent Woman Abuse
Alternatives to Aggression
214 N Hamilton
Madison, WI 53703
Contact: Kevin Browne
608-251-7611

Midwest Center for Human Services
2828 Marshall Court, Suite #210
Madison, Wisconsin 53705
Contact: Darold Hanusa
608-231-3300

Manitowoc
Catholic Social Services
PO Box 398
Manitowoc, WI 54220
Contact: James Neuser
414-684-6651

Lutheran Social Services
721 Park St
Manitowoc, WI 54220
Contacts: Tom Pritzl and Lynne Guinther
414-682-3332

Milwaukee
Nevermore
819 N Marshall
Milwaukee, WI 53202
Contact: Jim Welsh
414-272-6199

Batterers Anonymous
PO Box 08110
Milwaukee, WI 53208
414-342-8733

Milwaukee Task Force
for Battered Women and Children
414-643-1911

Neenah
Men's Support Group
Regional Domestic Abuse Services, Inc.
PO Box 99
Neenah, WI 54956
Contact: Eileen Connolly
414-729-5727

Ne-Naiah-Kaha-Kok
*Positive Indian Development Center
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Keshena, WI 54135
Contact: Joe Lawe
715-799-4398

Oshkosh
Life Resources208 State St
Oshkosh, WI 54901
Contact: Vic King
414-235-6239

Racine
Alternatives to Aggression
Family Services of Racine
420 7th St
Racine, WI 53403
Contact: Allen Vogt
414-634-2391

River Falls
Pierce County Mental Health Center
Box 670
Elsworth, WI 54011
Contact: Ann Roquet
715-273-3531

Sheboygan
*Violence Intervention Program
1415 N 13th St
Sheboygan, WI 53081
Contacts: Joeefira Hizon and Pamela Schultz
414-457-6710

Stevens Point
EVOLVE Family Crisis Center
1616 W River Dr
Stevens Point, WI 54481
Contacts: Laurie Larrison and Amy Kulhanek
(Services include a shelter and support groups for women, children and male perpetrators)

Sturgeon Bay
HELP of Door County
PO Box 319
Sturgeon Bay, WI 54235
Contact: Rose Gruber
414-743-8818

Superior
Human Resource Center
39 N 25th St E
Superior, WI 54880
Contact: Shirley O'Hare
715-392-8216

Waukesha
New Thresholds People to People
WCTI
800 Main St
Pewaukee, WI 53072
Contact: Mary Iverson
414-542-0123

Wausau
Children's Service Society
2420 Stewart Square, Suite E
Wausau, WI 54401
Contacts: Lee Shipway and Jeff Sargent
715-848-1457

*Unable to verify current information on program, 12/94.

complete treatment reduce or eliminate violent behavior.[16] Research also shows that only about half of those who begin counseling actually complete it. Also, even among men who stop physical violence, psychological abuse often continues. Therefore, abuser counseling should never be held out as a panacea, especially to battered women. Even among men who do complete abuser treatment, it should be stressed that abuser counseling does not guarantee future violence-free behavior. In the end, of course, it is up to the batterer to stop his violence. Further, battered women must decide whether they wish to remain in a relationship with the batterer. If the relationship continues, she is encouraged to maintain a safety plan for effective action in the event that violence re-emerges.

Conclusion

As another tool for reducing violence in our communities, physicians should consider screening men in their practice for violent behavior in the course of inquiring about current and pastrelationships. In conducting such assessment, physicians must be aware of local resources in their community for helping both victims and batterers, as well as their limitations. Finally, it must always be recalled that all violence assessments should have as an ultimate goal the safety of battered women and their children.

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We need you.

American Heart Association

Health education delivery by Wisconsin veterinarians

Douglas J. Reding, MD; Virginia Fischer, MS; Karen Lappe, RN, BSN; and Paul Gunderson, PhD, Marshfield

Established methods of health promotion for the general population are not as effective with rural populations, in part because conventional health education delivery systems may not penetrate isolated rural areas. In particular, the self-reliant behaviors of farmers make them less likely to seek traditional forms of health care, including health promotional activity. Yet farmers place a great deal of trust in their veterinarian and highly rate veterinarian integrity. Wisconsin veterinarians expressed an interest in the health of their human clients as well as the health of the animals in their care. An education demonstration project was developed to determine farmers' acceptance of veterinarians delivering human health information to their workplace (farms). Thirteen veterinarians who provide services in one north central Wisconsin county delivered skin cancer and sun protection information to farmers as part of their routine herd health checks. Participating farmers reported this to be an acceptable way to receive information about human health issues. This novel method of education delivery may be an effective means to disseminate human health information to difficult-to-reach rural populations. *Wis Med J.1994;93(12):627-629.*

In 1990, the National Institute for Occupational Safety and Health awarded the National Farm Medicine Center (NFMC), a 3-year cooperative agreement to fund the Wisconsin Farmers' Cancer Control Program (WFCCP). The goals of WFCCP were to identify problems the Wisconsin farming community faces in obtaining adequate health care for cancer screening, and to design and test interventions potentially capable of improving access to cancer education and screening.[1] Skin cancer was targeted because of its high incidence among farmers.[2] The majority of skin cancer can be prevented by avoiding exposure to the sun at peak hours and by the use of sunblock and adequate clothing to decrease sun exposure.[3-5]

By nature farmers are reported to be a healthy lot.[2] There is, however, an increased risk for specific types of cancer among farmers, namely skin, esophagus, lip, prostate, brain and certain hematologic malignancies.[2,6] Rural populations usually gain access to health care at lower rates than their urban counterparts.[7-9] Barriers to obtaining health care may be geographic, economic, or educational.[1]

Despite the fact that skin cancer is largely preventable, the incidence is rising by 4% per year.[10] Investments of time and money for prevention activities are far more cost effective than treating preventable diseases. Although American industrial settings have been targeted for some time with health promotion initiatives, the American farm is a relatively new target site.

In focus groups with 15 farm families, participants recommended education materials be kept simple and brief, education about healthy life styles and cancer risks begin with their children, and health promotion education be brought to the work place, ie, the farm. To address these recommendations, WFCCP devised a novel means of delivering skin cancer education to rural agricul-

This project was funded by the National Institute for Occupational Safety and Health, grant #U03/CCU506135-02. Dr Reding is an oncologist-hematologist with the Marshfield Clinic. Fischer is a health educator with the National Farm Medicine Center, a Division of Marshfield Clinic. Lappe is a program manager with the National Farm Medicine Center. Dr Gunderson is director of the Marshfield Medical Research and Education Foundation. Reprint requests to: Douglas J. Reding, MD, Marshfield Clinic, 1000 N Oak Ave, Marshfield, WI 54449. Copyright 1994 by the State Medical Society of Wisconsin.

Table 1.--Veterinarian sun protection project, survey responses by age.

Age (years)	No. of respondents (delivery)	% Agree or strongly agree* (delivery)	No. of respondents (mail)	% Agree or or strongly agree* (mail)
20-29	18	97%	15	79%
30-39	25	83%	62	66%
40-49	19	80%	63	71%
50-59	23	83%	50	67%
60+	9	50%	37	85%
	(11 missing)		(22 missing)	

* As appropriate or acceptable for a veterinarian to deliver human health information.

tural workers utilizing veterinarians. The specific purpose of this study was to determine the acceptability to farmers of having veterinarians deliver human health information to them.

Methods

WFCCP staff collaborated with the Wisconsin Veterinary Medical Association, the University of Wisconsin Veterinary School, and the American Cancer Society, Wisconsin Division. A skin cancer brochure (*Harvesting Health--Skin Cancer*) was developed to target the educational needs of farmers. The intervention was designed to test the acceptance by farmers of veterinarians delivering information on human health.

Two geographically separate rural northern Wisconsin counties were chosen for the pilot project. Both counties have large farming populations who live long distances from tertiary health care facilities. Two types of interventions were tested. Veterinarians in one county provided the WFCCP staff with their lists of dairy clients. The *Harvesting Health--Skin Cancer* brochure was mailed to 1,219 dairy farmers along with a letter from the principal investigator and health educator of the project, introducing the brochure and encouraging the farmer to read it.

In the second county, veterinarians actively participated in the project by delivering the sun protection and skin cancer information directly to 284 dairy farmers as part of the routine herd health visits. Prior to the intervention, veterinarians were briefed about the project by WFCCP staff and provided with educational materials on skin cancer and sun protection. The intervention consisted of the delivery of the *Harvesting Health--Skin Cancer* brochure, a copy of "Caps & Hats" booklet (the results of another skin cancer prevention project of the NFMC),[11] and a sample of SPF # 15 sunscreen.

Following each intervention, a two-page, 13-question survey was mailed to participating dairy farmers to determine the acceptability of having the veterinarian deliver human health information as part of herd health visits. Knowledge gain was not a survey objective. In keeping with the specific purpose of the study, both groups were surveyed to evaluate if there was a difference in the effect of veterinarian delivery on the degree of acceptance. Of the 1,219 farmers who received the mailed brochure, 249 (20%) returned the survey. In the county where veterinarians delivered the educational materials to 284 farmers, 105 (37%) responded. Survey data were analyzed for the level of acceptance to receiving human health information from veterinarians; these results were correlated with age and education of the farmer.

Results

Dairy farmers in both groups who responded to the survey were similar in age and education level. The majority of respondents were between the ages of 30 and 59 years and had a high school degree. Farmers in both groups, regardless of age or education level, felt it was acceptable and appropriate for the veterinarian to deliver human health information (Tables 1 and 2). Of the farmers in the "mail out" group, 66% agreed that receiving human health information from the veterinarian was useful. In the group receiving human health materials directly from the veterinarian, 86% felt it was an appropriate method of delivery (Table 3). Because the questions were not exactly the same on the two surveys, it was not possible to analyze them for statistically significant differences.

Discussion

In an attempt to overcome barriers to cancer prevention and early detection in a rural agricultural community, veterinarians were recruited to deliver skin cancer and sun protection information to farmers. The farmers surveyed were receptive to this novel way of providing human health educational material to farming and rural populations who may not be reached through conventional methods of health education and health care delivery systems. This veterinarian delivery system was developed in response to focus groups with farm families. Materials delivered to the farmers by the veterinarians were specially designed by WFCCP staff with an occupationally sensitive design and message appropriate to the farming community. The designed educational materials depicted farm situations which the farmers encounter

Table 2.--Veterinarian sun protection project, survey responses by education levels.

Education levels	No. of respondents (delivery)	% Agree or strongly agree* (delivery)	No. of respondents (mail)	% Agree or strongly agree* (mail)
8th grade or less	5	60%	21	67%
some high school	6	100%	11	60%
high school degree	67	82%	102	69%
some college	21	100%	64	67%
college degree	6	83%	49	63%
			(2 missing)	

* As appropriate or acceptable for veterinarian to deliver human health information

daily and the message was direct and brief.

The acceptance of this delivery system was higher in the farmer group directly receiving the materials from veterinarians as opposed to those farmers receiving only information through the mail. This may reflect the trust dairy farmers place in their veterinarian as opposed to mail delivered messages. The time required for delivery of the human health information and basic questions about the skin cancer materials added only minutes to the business intent of the veterinarian's visit. This additional amount of time was acceptable both to farmers and veterinarians. The veterinarian delivery system could be generalized to other types of veterinarians' practices.

Few adverse comments were recorded by farmers from either the mail out or veterinarian delivered group. This may reflect farmers' acceptance of information delivered to them by veterinarians. As a related issue, veterinarians made their intentions clear, that they did not wish to be involved in the practice of human medicine or examination of questionable skin lesions. Veterinarians freely recommended farmers seek medical attention if questions about a skin abnormality arose.

Due to the initial success of this demonstration project, further studies on farmers and their families would be appropriate to evaluate the desired changes in knowledge and behavior due to the intervention. Sample size associated with the intervention would be increased. Such a study may show this is an effective method to disseminate human health information to difficult-to-reach rural populations.

Table 3--Veterinarian sun protection project, responses by type of intervention.

Type of intervention	No. returns/contacts	% Agree or strongly agree* (delivery human health information)	% Agree or strongly agree* (talk about human health information)
Delivery	105/284	86%	68%
Mailout	249/1219	66%	52%

* As appropriate or acceptable for a veterinarian.

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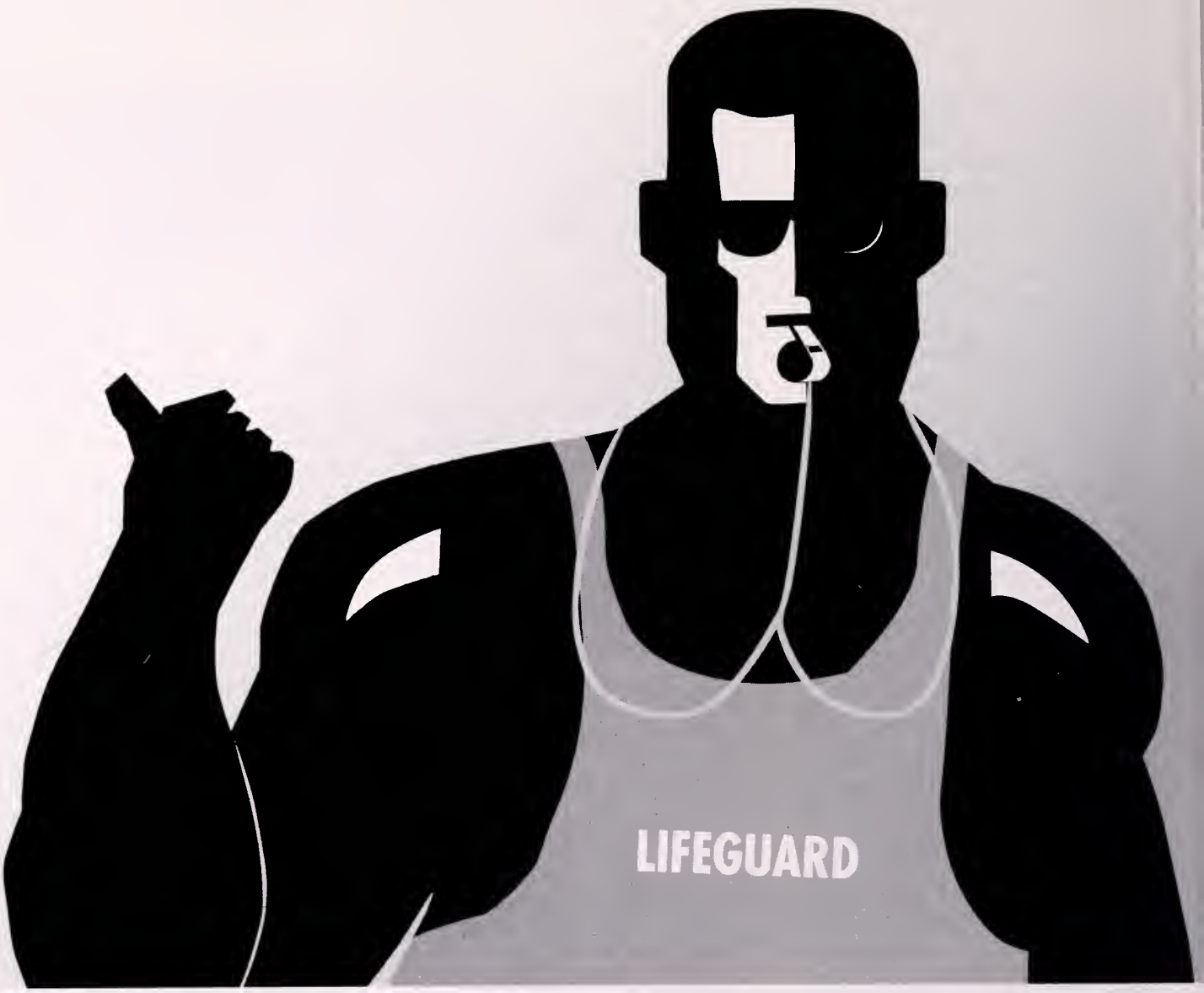

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Stark realities: Coping with federal and state self-referral paranoia

Alyce C. Katayama, JD, and Lisa A. Lyons, JD, Milwaukee

Effective Jan 1, 1995, physicians (including MDs, DOs, DDSs, DPMs, ODs, and DCs) may no longer refer their Medicare and Medicaid patients for "designated health services" to entities with which they have a "financial relationship," and the entities may not present claims for such services. These prohibitions are commonly known as "Stark II" after their original sponsor, Rep Fortney (Pete) Stark (D- Calif). They finally became law as part of the Omnibus Budget Reconciliation Act of 1993 (OBRA). OBRA '93 expands the preexisting "Stark I"[1] prohibition against self-referral for clinical laboratory services for Medicare patients, in effect since Jan 1, 1992, to 10 other "designated health services." There are, however, significant exceptions to Stark II's broad self-referral ban, including exceptions for group practices, in-office ancillary services, office and equipment leases, and bona fide employment and personal service arrangements.

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Regulations

Most of the provisions of the Stark II legislation require compliance not only with statutory language but also with "such other requirements as the secretary may impose by regulation as needed to protect against program or patient abuse." That physicians are obligated to comply with the law in its entirety on Jan 1, 1995, however, does not mean that the secretary of the Department of Health and Human Services (DHHS) is obligated to issue regulations by that time. If the experience with Stark I is any indication of what to expect, it will be a long time before we see final Stark II regulations—DHHS has not even hinted at when a draft might appear. The Stark I legislation was enacted Dec 19, 1989, and physicians were required to comply with it on Jan 1, 1992., but 24 months proved to be an insufficient time for the secretary to develop regulations. Proposed rules were finally published March 11, 1992, and have yet to be finalized.

In the discussion that follows, we have provided an exposition of the statute and some interpretation based on existing definitions, Medicare policies, and informal exchanges with individuals at DHHS. Any interpretation set forth here should be revisited when proposed regulations are issued and once again when those regulations are final.

Designated health services

Self-referral is prohibited for 11 designated health services: clinical laboratory services; physical therapy services; occupational therapy; radiology services, including MRI, CT scans, and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; inpatient and outpatient hospital services.

OBRA '93 included "radiology and other diagnostic services" among the designated health services. On Oct 31, 1994, technical corrections[2] eliminated "other diagnostic services" and added reference to MRI, CT, and ultrasound. This has had the effect of substantially narrowing the concept of designated health services and removing many diagnostic services previously considered subject to Stark II, such as audiology testing and ECGs.

Although the list may seem straightforward, application of the designated health services categories can be difficult. For example,

Medicare defines a prosthetic device very broadly, but hearing aids are not a Medicare benefit. Thus, current thinking is that the provision of hearing aids is not subject to Stark II.

Financial relationships

For purposes of Stark II a "financial relationship" is either an ownership or investment interest in the referred-to entity, or compensation arrangements between the referred-to entity and the physician. An ownership or investment interest may be through equity, debt, or other means and includes indirect ownership interests through other entities.

A "compensation arrangement" is defined broadly to mean "any arrangement involving any remuneration between a physician and an entity." Thus, remuneration flowing in either direction could constitute a compensation arrangement. Minor amounts such as the forgiveness of amounts owed for inaccurate or mistakenly performed tests, or the correction of minor billing errors are excluded from this definition.

The term "physician" for this purpose includes an immediate family member of a physician. Where such a financial relationship exists between a physician and the entity providing the designated health services, the physician may not make a referral for the service and the entity may not present a claim for a Medicare or Medicaid patient for that service. There are a number of exceptions to these prohibitions which are outlined below.

Stark II exceptions

Exceptions under Stark II fall into three categories: general exceptions applicable to ownership, investment interests, and compensation arrangements; exceptions applicable only to ownership and investment interests; and exceptions applicable only to compensation arrangements.

General exceptions

Physicians' services in group practices. Designated health services which are "physicians' services," are not prohibited by Stark II if the services are personally provided by (or under the personal supervision of) a physician in the same group practice as the referring physician.

"Group practice" is defined as "a group of two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association:

- in which each physician who is a member of the group provides substantially his or her full range of services through the joint use of shared office space, facilities, equipment, and personnel;
- for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed under a billing number assigned to the group and amounts so received are treated as receipts of the group;
- in which overhead expenses of and the income from the practice are distributed in accordance with methods previously determined;
- in which no physician who is a member of the group directly or indirectly receives compensation based on the volume or value of referrals by the physician, except for profits and productivity bonuses;
- in which members of the group personally conduct no less than 75% of the physician-patient encounters of the group practice; and
- which meets such other standards as the DHSS secretary may impose by regulation.

Stark II's definition of group practice has been loosened from certain proposed versionswhich would have required five or more physicians per office location. The expanded definition is due in part to proponents of "clinics without walls" (geographically dispersed medical practices of two or more physicians who form a single corporate entity which then serves as the employer of the physicians) who convinced lawmakers to include safeguards to avoid sham arrangements without defeating the multi-office group practice exception. For example, Stark II requires a group practice to bill under a single provider number, which allows DHHS to identify a group with extraordinarily high ancillary services.

In-office ancillary services. Stark II prohibitions do not apply to designated health services (other than durable medical equipment and parenteral and enteral nutrients, equipment and supplies) coming within the in-office ancillary services exception. To fit within this exception, these services must be:

- furnished personally by the referring physician, by a physician who is a member of the same group practice as the referring physician, or by individuals who are directly supervised by the physician or by another physician in the group practice;
- furnished in the building where the referring physician (or member of the referring physician's group) furnishes physician services unrelated to designated health services, or in another building which is used by the physician's group for clinical laboratory services or for the "centralized provision" of the group's designated health services; and
- billed by the physician, by the physician's group practice using a single billing number, or by an entity wholly owned by either the physician or the group practice.

The requirement that the in-office ancillary services be provided by individuals "who are directly supervised by a physician in the group practice" represents a sub-

stantial liberalization from Stark I. Stark I required that the individuals providing the services be "employed by" the physician or another physician in the group practice

To apply this exception, it is important to understand what is and is not durable medical equipment (DME). DME does not include infusion pumps, eye glasses, or contact lenses. Prosthetics and orthotics are not DME. Although eye glasses and contact lenses will be covered by Medicare when provided in conjunction with eye surgery, they are covered as a prosthetic device and not as DME. Hence when these items are covered by Medicare and provided under circumstances where Stark II would apply, they would need to be and could be brought within the in-office ancillary exception. When these items are not a Medicare benefit, they are not subject to Stark II at all.

The in-office ancillary exception to the Stark II prohibitions presents in sharp focus the fundamental fallacy of the Stark legislation. Essentially, Congress is telling physicians that if they order designated health services as members of a group practice, they are good people, but if they order those same services by referring a patient to a facility across the street in which they own an interest, then their medical judgment is suspect, over-utilization of services will occur, and the health care system will be forced to bear unnecessary costs. If physicians cannot be trusted to exercise appropriate medical judgment when referring their patients across the street, can they be trusted to do so when referring patients for the same service in their office, or, for that matter, when recommending surgery or any course of treatment for their patients? Society trusts physicians every day to make medically appropriate decisions that have an inseparable element of self-interest. In the Stark I and II legislation, Congress has arbitrarily and irrationally carved out certain decisions as somehow too tainted to be left to the physicians' medical judgment.

Compensation

Physicians attempting to comply with the group practice definition in Stark II (so that they can rely on the general exceptions for physician services in group practices or for in-office ancillary services) are no longer allowed to receive compensation in any manner which is directly related to the volume or value of their referrals. A physician in a group practice may be paid a productivity bonus based on services he or she personally performed or services "incident to" such personally performed services. There is some debate as to whether this applies to all ancillary services or only to those ancillaries which are designated health services. We believe DHHS will take the latter view.

In some groups, this compensation rule may require revamping compensation formulas but there are a variety of alternative methods for permitting physicians to share in the overall profits of the group. Ancillary service net revenues can be divided in any prearranged way which is unrelated to the volume or value of referrals. Ancillary income can be divided based on each physician's percentage of ownership in the group practice. The ancillary income can be allocated by seniority or distributed based on individual physicians' relative clinical produc-

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tivity (as measured by their direct patient care services, office visits, consultations, etc). Ancillary net revenue can even be used to offset expense allocations in compensation formulas.

How DHHS and the Office of the Inspector General will go about enforcing the compensation rule remains a mystery at this time. These agencies have not traditionally gathered data on physician compensation within group practices, and this intrusion will certainly mark the beginning of a new era in the practice of medicine.

Exceptions

Prepaid plans. Services furnished by organizations under arrangement with certain qualified prepaid plans are excepted under Stark II.

Investment securities. Stark II does not prohibit physician ownership of investment securities that may be purchased on terms generally available to the public, provided the securities are traded on a recognized exchange (eg, New York Stock Exchange, American Stock Exchange, or NASDAQ) and the investments are in a corporation with total assets exceeding $75 million. Stark II also exempts investment interests in certain regulated investment companies (mutual funds) whose shareholder equity exceeds $75 million. It is important to note, however, that Stark II offers no exception for physician ownership in other entities, such as limited partnerships, that furnish designated health services.

Ownership. A physician may have an ownership interest in, and make referrals to, hospitals in Puerto Rico, rural providers, and hospitals in which the physician is authorized to perform services (where the physician's interest is in the hospital itself rather than in a subdivision of the hospital). The exception for interests in rural providers applies to entities which furnish "substantially all" of their designated health services to individuals residing in such areas. This is a change from Stark I, which defined a rural provider as an entity located in a rural area.

Office and equipment leases. Office and equipment lease payments will not be considered a compensation arrangement if six conditions are met. These conditions are much like the fraud and abuse safe harbors for space and equipment rentals.[3] They include the requirements that the lease be in writing, have a term of at least 1 year and the lease would be commercially reasonable even if no referrals were made between the parties.

For purposes of the leasing and other Stark II exceptions the term "fair market value" means the value in arms-length transactions consistent with the general market value. For the leasing exceptions, fair market value also means a value consistent with the value of rental property for general commercial purposes (not taking into account its intended use), and not adjusted to reflect the additional value associated with the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.

Bona fide employment relationship. Any amount paid by an employer to a physician who is a bona fide employee will not be considered a compensation arrangement provided:

- the employment is for identifiable services;
- the remuneration is consistent with fair market value and does not take into account the volume or value of any referrals;
- the remuneration would be reasonable even if no referrals were made; and
- the employment meets such other requirements as the DHHS secretary may impose by regulation.

The bona fide employment relationship exception includes employment arrangements between physicians and any employer, the payment of remuneration in the form of a productivity bonus based on services performed personally by the physician is permitted. Tax law definitions are used to determine whether the individual is an employee of an entity.

Personal service arrangements. The exception for personal service arrangements is designed to keep typical independent contractor relationships from constituting compensation arrangements. The exception rests on six conditions: the arrangement must be in writing, signed by the parties, and must specify all of the services covered; the minimum term of the arrangement is 1 year; charges over the term of the arrangement must be set in advance, consistent with fair market value, and must not take into account the value or volume of any referrals or other business generated between parties.

Per-service or per-hour compensation is allowed as long as the other terms of the personal service arrangement exception are met: the services to be performed must not involve an activity that violates state or federal law; the aggregate services contracted for must not exceed those that are reasonable and necessary for legitimate business purposes of the arrangement; and the arrangement must meet other regulation requirements.

Under this exception, the existence of a medical director agreement between a hospital and a physician would not be deemed to prohibit the physician from referring patients to the hospital for designated health services.

The requirement that compensation must be set in advance may pose a problem for physicians and entities trying to form long-term relationships. One possible solution

is to use a 1-year contract with an option to renew, whereby renewal would occur only if, at the end of the initial term, the parties agree on compensation for the renewal term.

The Stark II exception for personal service arrangements specifically allows for Physician Incentive Plans (PIPs), provided that they do not operate as an inducement to reduce medical necessary services. PIPs, traditionally used by managed care organizations, are physician compensation arrangements that have the effect of reducing services provided to enrollees of an entity. If a PIP falls within the Stark II exception, compensation may be determined in a way that takes referrals into consideration.

Unrelated remuneration. A compensation arrangement does not include a hospital's remuneration of a physician if such remuneration is unrelated to the provision of designated health services. The scope of this exception, which seems to cover ground already covered by the employment and personal services exceptions, is not clear.

Physician recruitment. A hospital's remuneration of a physician to induce the physician to relocate to the hospital's geographic area is not regarded as a compensation arrangement if: the physician is not required to refer to the hospital; the amount of remuneration is not determined in a way that takes referrals into account; and the arrangement meets regulatory requirements.

Isolated transactions. Payment pursuant to an isolated transaction such as a one-time sale of property or of a practice will not be regarded as a compensation arrangement provided the amount of remuneration is consistent with fair market value, is not determined in a manner which takes into account referrals, is provided pursuant to an agreement which, would be commercially reasonable even if no referrals were made, and meets other regulatory requirements. Although not expressed in Stark II, DHHS has indicated that for a transaction to be truly isolated there can be no extended financing by the seller-physician, which will be looked at as an inducement to refer.

Other exceptions. An arrangement between a hospital and a group under which the qroup provides designated health services but the hospital bills them is excepted from Stark II if seven conditions are met. The critical condition is that the arrangement must have begun before Dec 19, 1989, and continued without interruption since that time. Payments by a physician to an entity as compensation for an item or service furnished at fair market value will not be considered compensation arrangements and hence would not prevent referrals by the physician to the entity for designated health services.

Sanctions for violation

Stark II carries many sanctions for prohibited conduct. At the most basic level, no payment can be made under Medicare or Medicaid for a service provided in violation of the prohibition. Any amounts which were collected must be refunded. Improper claims can be subjected to a penalty of up to $15,000. Circumvention schemes are subject to civil money penalties of up to $100,000. Finally,

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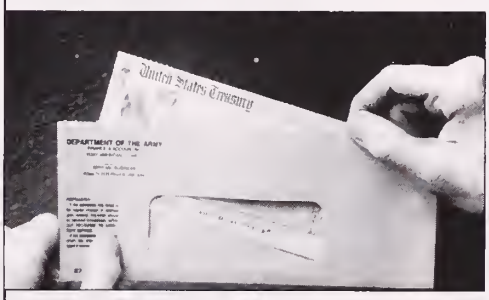

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failure to file required information reports can result in a civil penalty of up to $10,000 for each day the report is overdue. The fact that the statutory scheme calls for civil rather than criminal penalties will likely make Stark II the first choice for enforcement activity where conduct is prohibited by both Stark II and the anti-kickback statute.[4]

Reporting requirements

Entities providing designated health services must report their ownership arrangement to the secretary, must identify the designated health services they provide and must provide the name and UPIN of all physicians who have an ownership interest (or whose immediate relatives have an ownership interest) in the entity. Surveys to gather this information will be sent by the Health Care Financing Administration (HCFA) to some 320,000 doctors and 60,000 entities. The final survey instrument is in development now. HCFA's current plans are to give physicians 90 days to complete the survey and then deny all Medicare Part B claims.

Wisconsin legislation

Wisconsin has enacted legislation which mirrors the provisions of Stark II and by its own terms is to be given a consistent interpretation.[5]

Effective date

In general Stark II will be effective in Jan 1, 1995. Also on that date, the Stark I prohibition on self-referral of Medicare patients for clinical laboratory services will be extended to Medicaid. Most of the amendments to the Stark I exceptions and the new exceptions contained in Stark II apply retroactively to referral for Medicare clinical laboratory services made on or after Jan 1, 1992.

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1. Ethics in Patient Referrals Act of 1989, 42 USC §1395nn.
2. Social Security Act Amendments of 1994, P.L. 103-432.
3. 42 C.F.R. §1001.952(b) and (c).
4. Also referred to as the Medicare-Medicaid Anti-fraud and Abuse Amendments. 42 U.S.C. §1320a-7b.
5. Wis. Stats. §49.45(3)(L), 1993 Wis. Act 437.❖

Public health
Epidemiology of osteoarthritis

David L. Nordstrom, MS, Marshfield

OSTEOARTHRITIS (OA), also known as degenerative joint disease or osteoarthrosis, is the most common form of joint disease.[1] Arthritis, especially osteoarthritis, accounts for as much if not more disability than any other disease.[2]

The exact magnitude of OA in the United States is unknown. Prevalence of radiographic OA among adults aged 25 to 74 years is approximately 32.5% for the hands, 22.2% for the feet, 3.8% for the knees, and 1.3% for the hips.[1] Incidence of symptomatic OA is estimated to be 47 cases in hip and 164 cases in knee per 100,000 person years.[3]

The risk factor most strongly associated with OA is age.[4] As the population grows older, the burden of this condition may increase. So little is known about modifiable risk factors of OA that a recent national conference was unable to recommend means of prevention.[1] A new textbook by the American Public Health Association, however, recommends avoiding joint trauma, preventing obesity, and modifying work-related joint stress through ergonomic approaches.[5] The aims of this paper are to quantify the OA disease burden in Wisconsin and to estimate the proportion of OA that may be due to farming, a leading industry in the state.

Methods

In Wisconsin, all hospitals report to the Wisconsin Department of Health and Social Services certain summary information on all inpatient discharges. A public use data file for 1991 was obtained and analyzed. Data on OA of the hip are reported here.

Medical literature was searched in MEDLINE to locate studies of

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risk factors for OA. Those which addressed occupational exposures, particularly agricultural ones, were chosen for analysis. Studies of OA of the hip and knee were emphasized because disease in these joints is most disabling since it impedes walking.

Results

Disease burden. Wisconsin hospitals reported 2,387 inpatient discharges in 1991 with a primary discharge diagnosis of OA of the hip (ICD-9-CM code 715.15, 715.25, 75.35, 715.85, or 715.95) and 3,077 discharges in which the principal procedure was total hip replacement (ICD-9-CM code 81.51). Most (72%) of the hip replacements were performed in patients whose primary discharge diagnosis was OA.

This surgery occurs more frequently in women and the elderly (Table). The median age is 69 years. The median length of stay is eight days, and the median total charge, not including fees for physician services, is $14,417. Medicare was the expected primary payer for 67% of the hip replacements.

Risk factors. Factors whose possible association with OA has been studied include age, gender, ethnicity, race, occupational history, repetitive physical activity, trauma, abnormal biomechanics, genetic predisposition, and obesity.[4]

A variety of information underlies the suspicion of occupational factors.[6] OA is rare in paralytic limbs. OA of the right hand occurs in right-handed persons. Some studies have found excess OA of the wrist, hand, and elbow in jackhammer operators, of the hands of cotton millworkers, of the knee in coal miners and dock workers, and of the knee and hip in farmers.

In a large (n = 5,193), national cross-sectional study, investigators found that knee-bending demand of the job was associated with radiographic OA of the knee among both men (OR = 2.45) and women (OR = 3.49) aged 55-64.[7] This excess risk suggests that OA may develop only after a long period of relative occupational exposure. For persons in the 55-64 age group, the authors attributed 32% of the risk of OA of the knee to job-related knee-bending.

The Framingham Knee Osteoarthritis Study (n = 1,424) analyzed the relationship between occupation assessed during the initial 10 years of the Framingham cohort study and its relation to knee OA more than 20 years later.[8] Among men, the rate of radiographic knee OA in those with bending and physical demand jobs was significantly elevated (OR = 2.22). For radiographic knee OA, the proportion of OA attributable to jobs in which there was both knee-bending and physical demands was 15%. None of the results for women reached statistical significance.

Uncertainty concerning the relationship between work and OA is reflected by the presence of this condition in a list of occupational illnesses prepared by the National Institute for Occupational Safety and Health[9] and the absence of it in an occupational disease handbook developed by the American Public Health Association.[10] A recent review concluded that joint trauma is a strong risk factor (relative risk >4) and repetitive occupational use and obesity are moderate risk factors (relative risk 2-4) for OA.[5]

Agriculture. In a recent national health interview survey, farmers had the highest rate of disability of any "longest-held occupation" group.[11] Six recent epidemiologic studies have reported findings of association between farming and OA of the hip or knee. Using information from medical records, an HMO-based case-control study in a dairy farming area of Wisconsin estimated the risk of symptomatic OA of the knee in men aged 20 to 60 to be 4.3 times greater in farmers than in white collar workers.[12] In Sweden, a case-control study that obtained subjects' occupational history since age 15 by questionnaire reported relative risk of hip surgery for OA of 3.2 (1.8, 5.5) in men aged 55 to 70 who had farmed more than 10 years.[13] Risk did not, however, consistently rise with years in farming. A case-control investigation in England recruited subjects from urological outpatients to avoid selection bias.[14] Ascertaining lifetime work history by interview, it estimated risk of severe OA to be 2.0 (0.9, 4.4) in men aged 60 to 75 with more than 10 years of farming.

In a cohort study in England, researchers randomly selected a sample of farmers and office workers from general practice lists. After determining their past work history and disease status by interview and examination, they reported a risk of hip OA of 9.3 (1.9, 44.5) in male farmers aged 60 to 76.[15] Risk increased with years in farming, although only two categories were used. Follow-up of 250,217 persons in Sweden who reported the same occupation in three consecutive censuses revealed risks of subsequent hospital care for OA of the hip of 3.78 (2.91, 3.88) in male farmers and 1.47 (0.86, 2.85) in female farmers.[16] Of all occupations among men, farmers had the highest risk. Finally, a case-control study in Sweden in which cases had prevalent disease

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Age and sex of total hip replacement discharges from Wisconsin hospitals in 1991.

Age	Male	Female	Total
0-44	91	67	158
45-64	456	400	856
65-84	716	1170	1886
85+	38	139	177
Total	1301	1776	3077

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with radiologic evidence of structural or joint space changes reported OA hip 12 (6.7, 21.4) times greater in male farmers than male urban residents aged 40 to 64.[17] No difference was found between farm and nonfarm females.

Occupational titles are only a rough guide for exposure assessments,[16,18] therefore the above studies that examined specific occupational tasks are especially valuable. Regularly driving a tractor was associated with hip OA in Sweden [RR = 2.2 (1.3, 3.9)][13] but not in England [RR = 0.9 (0.4, 1.8)].[14] Severe OA of the hip was associated with prolonged standing at work [RR = 2.7 (1.0, 7.3)] and heavy lifting [RR = 2.5 (1.1, 5.7)].[14] Several occupational activities, however, revealed no association with hip OA; for example, sitting, bending, kneeling, squatting, walking, running, or climbing.

Discussion

OA is a common, disabling disease with unknown etiology. It is theorized that OA results from overload of the subchondral bone of the joints, where the main stress is absorbed, leading to micro-fractures, and later to stiffness.[19] Total hospital charges for hip arthroplasty in Wisconsin in 1991 exceeded $44 million.

The above papers have reported relative risks of hip OA in farmers ranging from 2 to 12. This is evidence of moderate to strong association. The available data can be used to estimate the population attributable risk or etiologic fraction.[20] Conservatively, suppose that the true relative risk is 4. If we assume that 5% of the population over age 50 in Wisconsin has farmed more than 10 years, then 13% of the risk of hip OA in Wisconsin may be attributed to farm work.

Contrasting explanations may be considered in the possible farming-OA equation. Farmers with hip pain may seek treatment with the expectation that they will return to work with impaired function. Alternatively, farmers may delay surgery due to uncertainty about hip function at discharge. There may be a selection for health in rural populations, since hip OA is disabling.[21]

Most of the agricultural studies to date are of moderate size, and larger investigations may help to clarify associations with specific physical activities. Besides mechanical factors related to work tasks, other possible explanations for the link between OA and farming include a high incidence of infections, such as brucellosis, or developmental hip disorders.[14] Hereditary transmission also deserves further consideration.[22]

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PIC Wisconsin: Continued commitment to physicians

Richard W. Edwards, MD, Richland Center

PIC Wisconsin continues to reinforce and demonstrate its longstanding commitment to physician policyholders and shareholders, as well as to the entire Wisconsin health care community, in daily operations and through special programs.

Among many things, PIC Wisconsin has decreased rates for those insured this year and announced that it will reward their loyalty with a dividend in 1995 as well. The company is also helping to fund an innovative outcomes research program through the State Medical Society that PIC Wisconsin believes will assist physicians in their practices and eventually benefit patients.

Fourth policyholder dividend

PIC Wisconsin will return approximately $2 million to eligible policyholders through dividends. This was made possible by favorable operating results, reflecting both better than anticipated actuarial projections and overall positive outcomes featuring sound administration, skillful claims management, and wise investments.

With this latest dividend, the company will have returned more than $9.3 million to its policyholders. PIC Wisconsin previously declared dividends in 1989, 1990, and 1991.

Influencing an improved claims climate

PIC Wisconsin recognizes that actual underwriting results may not always be more positive than actuarial projections. But, in recent years, the claims frequency for Wisconsin has decreased, while national data indicates the opposite. As the largest carrier of medical professional liability insurance for this state, PIC Wisconsin cannot help feeling that its operating philosophies--emphasizing defense against unwarranted claims and loss prevention strategies--have contributed to this improved claims climate.

This enhanced claims environment has also helped stabilize premium rates. In fact, PIC Wisconsin has reduced rates across the board for Wisconsin physicians and surgeons by 7% this year. This reduction makes its current rates lower than those of 1988, despite the significant accumulative effect of inflation during the intervening years. This is noteworthy, given the historic volatility and sharp rate hikes associated with the medical professional liability market over the past 20 years. This positive influence on rates is related to PIC Wisconsin's establishment as a physician-owned company with the cooperation of the State Medical Society.

A key to PIC Wisconsin's success has been the partnership it enjoys with its policyholders, and particularly with the SMS. Simply stated, the company listens to those it serves and involves them directly in governance and operations through its board of directors and its committees overseeing claims, underwriting, risk management, and investments.

PIC helps fund new SMS study

With the SMS, this concept of partnership goes further and is exemplified by a new joint research project. PIC Wisconsin has pledged to help fund a pilot study on patient outcomes through the SMS Charitable, Educational and Scientific Foundation (CESF). The goal is to encourage Wisconsin physicians to participate by providing statistics on certain patient outcomes concerning diagnosis, treatment, and subsequent health status of lower back pain, asthma, depression, and angina.

The PIC board of directors has established an endowment to help fund CESF projects, of which the patient outcomes study is among the first. To encourage others to contribute to the CESF, PIC Wisconsin will also match donations two-to-one, up to $25,000.

Tomorrow's solutions today

Through the company's close relationships with physicians, PIC Wisconsin has learned that they, their corporate entities, and their medical staff require more than insurance contracts today. PIC Wisconsin realizes that it has to be prepared to solve myriad professional liability protection challenges. These solutions include aggressive claims and legal defense services that reduce or eliminate the costs associated with frivolous claims and hold indemnity payments to fair and appropriate levels; they involve hands-on, comprehensive risk management services, and flexible coverage and rating options for groups practices, clinics and solo practitioners.

PIC Wisconsin has responded to contemporary needs of physicians as well. For example, it enacted special coverage features like its HIV endorsement that offers an automatic benefit to any participating policyholder stricken by the virus. It has also developed a program for emergency department physicians that gives them the option of having their premiums based on number of patients they see rather than the standard ER physician classification.

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Dr Edwards is chair of the PIC Wisconsin Board of Directors. He has practiced with the Richland Medical Center, Ltd., in Richland Center since 1967.

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This depth of prompt and responsive customer service can only stem from a well-developed, beneficial collaboration between company management and staff and those insured by PIC. While daily operational aspects focus on fulfilling this continuing working relationship with policyholders, the foundation that enables PIC Wisconsin to plan long-term strategies is based our financial strength and integrity.

Although PIC Wisconsin has been in business for less than a decade, it has received a strong rating from the A.M. Best company. PIC Wisconsin is noted within its industry for strong and conservative financial ratios, assets and policyholder surplus growth, strength in claims reserves, and operating efficiencies. Thus, the value of its shareholders' investments has appreciated.

Recently, PIC successfully completed the first step in a continuing process designed to offer shareholders opportunities to recognize value for their initial investments. A stock redemption program enabled many individuals, principally retirees and surviving spouses, to each redeem up to 25 shares of PIC common stock.

Meeting challenges together

Wisconsin physicians, like their colleagues in other states, face many unknowns that continuously arise from the dramatic changes occurring within the health care industry. One constant in this fast-paced, ever-changing health care scene is PIC Wisconsin's continued pledge to provide Wisconsin physicians superior medical professional liability protection and related services.

Together, PIC Wisconsin, the State Medical Society, and PIC's physician policyholders have conquered many challenges and overcome many obstacles since their partnership began in 1986. The past success of this partnership suggests continued success in the years to come.❖

Medical facilities must report information about induced abortions to state

The Wisconsin Center for Health Statistics, which operates the reporting system on induced abortions in the state, is updating its list of providers and facilities that should report information on induced abortions. The annual reporting deadline is Jan. 15. Providers, who need reporting forms and instructions, may contact Jan Silbaugh, Center for Health Statistics, Division of Health, P.O. Box 309, Madison, WI 53701-0309 or call (608) 266-8855. Wisconsin's induced abortion reporting system (IARS), created under Wisconsin Statute 69.186, has required since 1987 all Wisconsin medical facilities (hospitals, clinics or others) to report demographic and other information on each individual who obtains an induced abortion in the facility. A reportable induced abortion is defined in statute as "the termination of a uterine pregnancy by a physician of a woman known by the physician to be pregnant, for a purpose other than to produce a live birth or to remove a dead fetus." According to statute, all information that could identify facilities or patients is confidential.❖

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AIR FORCE

Mini internship report: Creating new and stronger allies

Shari Hamilton, assistant editor

"Don't walk ahead of me because I might not follow. But walk beside me and be my friend."

We've all heard the axioms about walking a mile in another's shoes to really find out what life is like for them. I have a hard time, however, buying into that theory. It's difficult for me to believe that non-physicians can ever know precisely what it is like to have to make rapid-fire, life-or-death decisions, to know that every decision made could be reviewed closely, or to bear daily responsibility for decisions that stand to forever influence another person's health and well-being. That's why I prefer the sentiment expressed above as a description of the intent of the mini-internship program. Don't try to wear my shoes. You don't know where they have been, and they most likely won't fit you. *Walk beside me and be my friend.*

Earlier this year, I took my shoes up north to Ashland to walk along side physicians practicing in one of the state's poorest economic areas. It's home to me, of a sort, having grown up some 40 miles away. I understand the culture. I recall the cold winds that make winter welcomes seem even warmer, the beauty of the brilliant fall colors, the immense inland ocean, the strength of the people, and the endless piles of ice and snow.

When I heard there was an opening in an internship program "way up north," my curiosity was piqued. I called our affable freelance photographer Bob Rashid and he quickly agreed to the adventure. Within days, we were making tracks north to learn what medicine was like from the physician's side of the stethoscope, at least as much as was possible in the time frame and format allotted. We caught a ride with Maureen O'Brien, SMS field representative, who was making a swing through her district and was helping to organize the Ashland mini-internship.

As a former newspaper reporter and editor and a self-declared skeptic, I cautiously admit my expectations were a little jaded at the start. Was there some agenda I didn't know about involved with this mini-internship stuff? What were the proponents hoping to accomplish? Were we going to be a captive audience listening to doctors on soapboxes proclaiming that they alone hold the key to resolving all the nation's health care delivery problems? Would I, heaven preserve me, be paired with a doctor who would try to teach me 4 years of studies in one afternoon, lecturing endlessly on a topic of little interest to me? (Don't get me wrong. I'm the first to admit I always need more education and I hold great respect and affection for doctors and medicine. It's just that I just have this recurring nightmare that someone will corner me and make me memorize Dorland's Illustrated Medical Dictionary.)

My trepidations, although combined with a great deal of interest in the possibilities of the program and a strong desire to learn more about medicine, I think, put me at about a par with many of the other profes-

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Physician participants in the Ashland mini-internship program

Grace Heitsch, MD, pediatrician
David Saarinen, MD, family physician
John Oujiri, MD, family physician
Richard Searl, MD, family physician
Andrew Matheus, MD, family physician
Robert Pierpont, MD, family physician
Ivan Teoh, MD, general surgeon
Scott Warren, MD, orthopedic surgeon
John Schulz, MD, anesthesiologist
Mark Belknap, MD, chair

Grace Heitsch, MD, burns some "proud flesh" off 3-week-old Samuel's umbilicus during an infant well-child exam, then discusses safety tips and infant development with Samuel's mom. Dr Heitsch, a Missouri native, graduated from the University of Minnesota Medical School at Duluth, then opted to stay near Lake Superior. She was attracted to practice in Ashland because of the opportunity to work part-time and, subsequently, spend more time with her husband, a computer consultant, and young children. (Copyright photo by Bob Rashid)

A caring and compassionate man, Andrew Matheus, MD, takes a few extra minutes to talk with a young patient with pelvic inflamatory disease and listen to her concerns. Dr Matheus, like many of his colleagues, takes his doctoring out of the office and into the community. One of the patients we saw was a young man with asthma Dr Matheus had seen in town the night before. Concerned about the young man's cough, Matheus had encouraged him to stop by for a check-up so they could treat his health problems before they escalated into a crisis. (Copyright photo by Bob Rashid.)

Continued from preceding page
sional participants in this and past internships. We weren't sure what to expect when we walked into orientation.

What we found helped allay my fears. In a corner of the room, huddled around the hors d'oeuvres (probably their first food of the day) were several doctors somewhat anxiously preparing to embark on their first mini-internship. They, too, had reservations. They had concerns about how their patients would react to strangers in the examining room. Would the patients feel awkward and fail to share important health information? Would the interns prove to be a nuisance and get in the way? That night in the hospital cafeteria, facilitated by internship program chair Mark Belknap, MD, we all got to know each other a little. It would prove to be a big benefit in the morning when we actually could recognize each other in the halls. We discussed the ground rules and shared our expectations, goals, and ideas. We set in place the forms for the bonds that would be cemented during the 2-day joint venture.

The bonds, it should be stressed, are the real goals of the mini-internship program. This project gives physicians a chance to establish important bonds--based on a growing respect and friendship--with influential people. Good candidates are those people who may have great influence in the institutions in which you work or within the communities in which you live, such as hospital board members, state and federal lawmakers, attorneys, and the media. Medical society staff, like me, who participate in the internships don't claim to be "influential," but can better represent you in interactions with the media, the Legislature, and the public after we have spent a day or two walking next to your shoes.

Lawmakers and media are a lot like physicians, although members of the various professions might take

offense. Physicians refer to others they know, respect, and trust. Lawmakers and media with questions pertaining to medicine refer to physicians they know, respect, and trust. The mini-internship provides a platform on which those relationships may form. The Illinois medical society invited a trial attorney to participate and, as a result, he stopped accepting medical malpractice cases! You may, however, have other individuals with whom you would like to build bridges first.

The mini-internship program allows interns to put names, faces, and personalities with the white coats and surgical blues and greens. As they walk with physicians through their day, interns learn in far less dramatic ways than these words might suggest what it is like to be Dr Jonah swallowed by the giant whale of a red-tape-lined health care system. (In other words, a physician trying to find a mental health therapist that will work with a depressed teenage recovering alcoholic when a bureaucracy says the teen can only see a person she dislikes.) Or, what it is like to be Dr David, flinging a rock of common sense into a process controlled by a distant and detached insurance reviewer.

I won't give you a play-by-play of my entire internship experience, although I assure you it made such a strong impression on me that I recall the patients vividly. Most patients welcomed the interns into the room and spoke openly. I think we only had three rejections in two days and those were for very understandable and personal reasons. In the examining rooms, we listened to the patients' concerns, watched the examination, and then observed the diagnosis and any subsequent recommendations for treatment. Physicians explained procedures as they went along so both interns and patients would understand. The doctors answered our questions between examinations and explained why they had chosen one course of treatment over another.

The physicians I walked with for two days seemingly shared no common agenda, other than an intense drive to deliver top quality medical care--with the emphasis on care. They were as unique and diverse as you might expect in any group of professionals. Once again, the experience brought home to me the message that Wisconsin physicians, like other Wisconsin citizens, are independent thinkers with unique approaches for dealing with their patients, the government, and their peers.

"I know you're having fun, but are you learning anything?" questioned one of the physicians assigned to me after I practically bounced up and down relating yet another remarkable episode in my mini-internship program (that cynical stance long abandoned).

I tried to tone down my enthusiasm a little after that. But remember, these wereunprecedented experiences for me. I'd never before seen surgery. I witnessed a birth (It's much easier to watch than participate); hip replacement surgery; a knee anthroscopy; an appendectomy; the reconstruction of a crushed finger; and the removal of plates and screws from an ankle. Each procedure was amazing. I was awestruck by the amount of preparation and training, physicians must have before each patient encounter. I was stunned by the realization that just a very brief encounter with a physician can have an incredible effect on a person's life and well-being. For example, look at how just 13 minutes on an operating table can change the quality of life for an elderly person with a broken hip.

But no less fascinating to me was to watch the care pediatricians and family physicians took with infants and parents during well child exams; the gentleness with which they examined all those in their care; and the ways the doctors coped inside

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Watching Dr Scott Warren work was a mesmerizing experience for intern Shari Hamilton who had never before seen surgery "up close and personal." Hamilton observed Dr Warren removing metal plates and screws from an ankle, inserting a pin in a finger crushed by a power tool as well as performing a knee anthroscopy and a hip replacement. Dr Warren carefully explained the procedures and discussed plans for rehabilitation. Dr Warren chose to practice in Ashland because he grew up in the Northland and thinks of it as home. (Copyright photo by Bob Rashid.)

A doctor's work is never done. Family physician Rick Searl, MD, dictates patient notes while "on hold" awaiting information on another patient. The interns watched as the physicians spent moments between patients charting information, checking lab results and dictating notes or follow-up questions to reach closure on one patient before turning to another. Dr Searl and Dr Andy Matheus are working in Ashland, a physician shortage area, as part of a physician loan forgiveness program. (Copyright photo by Bob Rashid.)

Continued from preceding page

and outside of the examination room with decisions patients had made to stop taking medicine, to take someone else's medicine, or to continue to smoke when they had asthma or were pregnant. The ways they respectfully expressed concern but always left the door open for the patients to make the decisions and to continue to come back and receive much-needed care. It was obvious that these physicians were treating their neighbors, the people they sat next to in church on Sundays, the classmates and future classmates of their children.

Having grown up in northern Wisconsin where it was common for classmates and their family members to go without medicine because their families couldn't afford the drugs, it was extremely heartening for me to see physicians follow up with their patients as to how they would be able to access prescriptions and other treatments. I saw doctors who were well familiar with working with Medicaid, Medicare, Indian Aid, and other programs, as well as variety of insurance companies.

I found myself caught up in studying the contrasting styles of the doctors. All thoughtful, a few comedic, some quiet. Some seemingly working all the time; some finding the balances they need between family and practice time. One relating the frustrations of providing care for people who don't pay their bills. Another doctor admitting he has no idea which patients pay and which don't. Many worried about health system reform. Few with definite answers. Most with strong support for various reform concepts. Most worried more about their patients under health system reform than themselves and wanting to protect their ability to deliver the type of care they believe in without outside interference.

I witnessed firsthand the many things we Americans do to ourselves that drive up the costs of health care: the teens having babies; the putting off of health care until conditions reach catastrophic stages; the smoking, drinking, and overeating. But I also saw the good things: the young parents guarding the well-being of their firstborn; the mom breaking unhealthy cycles to try and give her daughters a better shot at life than she had; and the physicians working to make sure this generation of Wisconsin

An exhausted mom, 18, and somewhat apprehensive young dad get the first real look at their 7 lb, 4 oz baby boy, delivered with the help of Rick Searl, MD. About 500 babies are born in Ashland each year. (Copyright photo by Bob Rashid.)

residents is healthier than the last.

The mini-internship experience concludes with a debriefing dinner during which interns and physicians share impressions. The atmosphere was warm and friendly--we'd gained each other's trust. All of the physicians commented about how easy it was to get permission to have the interns observe. Several voiced surprise that their patients were just as candid with the interns in the room as they were normally.

My only concern with the mini-internship is that it allows interns to experience so many of the intriguing and interesting aspects of medicine, that the downsides of medicine that we are trying to change may go unnoted. More efforts must be made to draw attention to the reams of paperwork, the insurance run-around and increasing government restrictions that can impedequality health care.

When I returned to Madison with my enthusiastic reports, I was teased by a couple of colleagues for becoming the "mini-internship poster child." There's no doubt I am a proponent of the mini-internship program now. But like many of you, I had reservations at first. I didn't want the program to be a public relations gimmick and it's not that at all. The mini-internship program gives real people--physicians and interns--a chance to share concerns and information about the present and future of health care in a very comfortable format. It can turn adversaries into allies and skeptics into supporters.

As for me, my internship experience left a lasting positive impression. My respect for your profession has grown for I have seen firsthand how hard you work, the amazing skills you possess, the challenges you face, and the intensity with which you care. The bonds of understanding have been strengthened, you have an even stronger ally--and I didn't even have to wear your shoes. ❖

CES Foundation awards two research grants

THE SMS CHARITABLE, Educational and Scientific Foundation has voted to support research projects conducted by the department of surgery and the department of medical microbiology and immunology at the University of Wisconsin Medical School.

Under the direction of Anthony M. D'Alessandro, MD, assistant professor of surgery, transplant service through the department of surgery, the effect of continuous hypothermic perfusion of livers on Kupffer cell activation will be studied. This has been suggested as a possible cause of preservation injury following liver transportation.

The second research project is being conducted by Alexander Sharko, MD, with C. David Pauza, PhD, professor of the department of pathology and laboratory medicine, supervising his work. Dr. Sharko's research is to develop a vaccine for human immunodeficiency virus type I (HIV-1). While a second year medical student, he formulated a plan to covalently link the non-toxic endotoxin derivative, monophosphoryl lipid A (MLA), to gp120 for use as a vaccine against HIV.❖

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Consider a unique practice opportunity that includes both clinical medicine and academics in a new federally funded community health center in Wausau, Wisconsin and affiliated with the University of Wisconsin Family Practice Residency Program. The community health center will target serving the Federally Designated medically underserved population and meets the HPSA certification for the loan repayment program.

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Teen Workshop on Health brings safety message to Wisconsin kids

More than 1,200 Wisconsin 7th and 8th graders attended the SMS and SMS Alliance-sponsored workshop on health, titled, "Violence and Respect."

The half-day Alliance-organized program drew rave reviews in student evaluations, with students ranking 4.6 on a five-point scale the quality of the information they received through the workshop. Three speakers and a youth drama and dance group, West Bend Pride, took the stage.

SMS President Richard G. Roberts, MD, was a featured speaker with an interactive presentation on gun safety. "Gun deaths aren't just a big city problem confined to gang violence," Roberts told the students gathered in La Crosse and Oshkosh. "Gun deaths don't just result from hunting accidents. Kids can be injured by guns anywhere."

The SMS president urged students to think carefully before making any contact with a gun and realize that these weapons can and are very dangerous.

"Let me tell you as a doctor, I know bullets don't discriminate when they hit your body. They don't care if you're young--class president, class clown or a good athlete. Bullets don't care if your skin is white or if your hair is black. They just rip through your body tissue, destroy vital organs and wipe out your dreams. Bullets do things to the human body that doctors--no matter how hard we try--cannot repair," Roberts said.

Trigger locks were given to students would could correctly relate information cited earlier in Roberts' remarks as to the distances bullets may travel, the number of Wisconsin youths killed each year, etc.

Dr Roberts leads a conflict resolution demonstration at the Teen Workshop on Health.

Students vied eagerly for the chance to answer the questions correctly.

When questioned, more than half of the students at each workshop location indicated guns were kept in their homes. Many expressed concerns about personal safety. All of the workshop participants were given gun safety materials and checklists to share with their parents.

Next, West Bend Pride, a jazzy dance-drama group of students of all shapes and sizes from West Bend, took the stage. The group combined song, dance and skits in an effort to help students understand a little bit of kindness and caring can go a long way to ease an otherwise difficult situation. The young performers drew positive reviews for their display of enthusiasm and dedication.

Bob Lenz, a motivational speaker from Appleton, was a big hit, bringing kids a strong message of self respect and awareness. Lenz has a knack for distilling problems down to their bare essence. "Sometimes your girlfriend or boyfriend will say, `We gotta do it (have sex). I love you.' You know what?," Lenz questioned. "Love is a commitment. It's not about having sex. I walk around the halls in middle schools and high schools all over this state and hormones are bouncing off the walls there. They almost knock you over.

"Instead of saying in a fit of passion, `I love you," these kids should be telling the truth. They should be saying, `I hormone you,'" Lenz noted, generating approving giggles and nods in his audience.

Adrienne Diercks, of Possibilities, Inc., Minneapolis, discussed how participants could make a difference in their own self esteem and the self esteem of others. Students jumped to the microphones in an effort to share what they had learned helps them feel good about themselves so they feel strong enough to make healthy choices in their lives.❖

Physician Briefs

***Daniel Albert, MD**, professor and chair of the UW Department of Ophthalmology and Visual Sciences, has been named editor of Archives of Ophthalmology, a publication of the American Medical Association.

***Pamela J. Butler, MD**, has joined All Saints Healthcare System. Dr Butler, a dermatologist, will work at All Saints Kurten Medical and is a graduate of the University of Texas.

***Michelle Laundrie Cihla, MD**, joined the Rhinelander Medical Center clinic staff as a dermatologist.

Michael J. Dunn, MD, a native Milwaukeean and a nationally recognized kidney specialist, has accepted the offer to serve as dean of the Medical College of Wisconsin starting in January, 1995. He is currently the Hanna Payne professor of medicine at Case Western Reserve University School of Medicine and director of the division of nephrology at University Hospitals of Cleveland. Dr Dunn received his medical degree from the Marquette University School of Medicine, and served an internship and residency in internal medicine at Johns Hopkins Hospital, Baltimore. He took a nephrology fellowship at the University of North Carolina for a year, and spent three years of military duty as a research internist at the Walter Reed Army Institute of Research. Dr Dunn served as a clinical nephrologist at the University Hospitals of Cleveland for almost two decades.

***Mary C. Flynn, MD**, has joined Physicians Plus Medical Group as an internal medicine specialist.

***Orlando M. Francisco, MD**, a physician in Tomahawk since 1962, was recently honored with the Sacred Heart Hospital Foundation prestigious "Partner in Health" award for his "outstanding contributions" in the health field. He received his medical degree at the University of St. Tomas in Manila. He completed his residency in Milwaukee.

Donald Garland, MD, occupational medicine, has joined the Occupational Health program of All Saints Medical Group of Racine. Most recently in private practice in Minneapolis, Dr Garland specialized in treating patients who have been hurt or injured in the work environment. He received his medical degree from the University of Rochester School of Medicine and his master's degree in industrial health from the University of Michigan.

Robin Gavelin, MD, has joined Physicians Plus Medical Group as a pain management anesthesiologist.

***Timothy Harrington, MD**, has been named regional medical director of Physicians Plus Medical Group. A rheumatologist, he will divide time

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Annual meeting resolutions due

THE 1995 annual meeting of the State Medical Society of Wisconsin will convene at 4 PM on Friday, April 7, 1995, at the Grand Geneva Resort, in Lake Geneva.

Resolutions must be submitted in proper form to the executive vice president's office no later than 2 months prior to the opening session of the House of Delegates. The deadline for receipt of resolutions is Friday, Feb 3, 1995.

It is important that all resolutions be submitted in time so they can be included in the handbook. Unanimous consent of the House of Delegates shall be required for the introduction of any late resolutions, except those that are submitted by the Board, a Board member or the Society's constitutional officers.

When drafting resolutions for submission, please give close attention to the following: 1) the title of the resolution should appropriately reflect the action for which it calls; 2) information contained in the resolution should be checked for accuracy; 3) the resolves should stand alone, since the House adopts only the resolves and the whereases do not appear in the proceedings.

Fiscal notes will be added to all resolutions whose implementation would require funds not normally included in the SMS budget. For each resolution submitted, a sponsor should be in attendance at reference committee hearings to provide background information.

Reference committees will meet on Saturday, April 8, 1995 at 8:30 AM and the second session of the House will begin on Saturday at 3 PM.❖

Continued from preceding page
between his practice and the administrative post.

***John T. Heinrich, MD,** has joined the Milwaukee Orthopaedic Group, Ltd., and the staff of Sinai Samaritan Medical Center. He completed his undergraduate studies, medical school and orthopaedic surgery residency at the University of Wisconsin-Madison. He recently completed an orthopaedic sports medicine fellowship at the Southern California Center for Sports Medicine, Long Beach,California.

Mark Juckett, MD, has been appointed assistant professor of medicine in the division of hematology/oncology at the Medical College of Wisconsin.

***Christopher Kearns, MD,** has established his practice specializing in urology at 2015 E. Newport Avenue, Milwaukee.

***Raymond W. Knight, MD,** has been named medical director of the Clinical Practice Division of Kenosha Hospital and Medical Center. He has practiced internal medicine, hematology and oncology in Kenosha since 1977. He received his medical degree from Ohio State University. He interned at Rush Presbyterian-St. Luke's Medical Center, Chicago. After a tour of duty in the Navy, he returned to Rush Presbyterian for his residency and fellowship.

Venkat Mantha, MD, has joined Sacred Heart-Saint Mary's Hospitals, Inc. as an anesthesiologist. He practiced anesthesiology in Great Britain for 10 years and most recently completed a residency in anesthesia at Rush-Presbyterian-St. Lukes Medical Center, Chicago. He is a graduate of Osmania University, Hyderabad, India. He received his diploma in anesthesia in London, and is a fellow of the Faculty of Anesthesiologists in the Royal College of Surgeons in Ireland.

Daniel J. McCarty, Jr, MD, director of the Arthritis Institute and Will and Cava Ross professor of medicine at the Medical College of Wisconsin in Milwaukee, was named a Master of the American College of Rheumatology during the college's National Scientific Meeting in Minneapolis, in October. He received the college's highest honor, The Gold Metal, at the annual meeting in 1993.

Ann Nattinger, MD, MPH, assistant professor of medicine at the Medical College of Wisconsin and breast cancer researcher, has been awarded a four-year $738,000 grant from the US Army Medical Research and Development Command. She will study variations in and outcomes of care after initial treatment for breast cancer. A native of Libertyville, Illinois, Dr Nattinger received her medical degree from the University of Illinois, Chicago.

Gregory Pae, MD, has joined All Saints Healthcare System. Dr Pae, an obstetrician/gynecologist, will work at the St. Luke's Hospital Medical Office. He is a graduate of the Rush Medical School in Chicago.

Richard A. Proctor, MD, Professor of Medicine and Medical Microbiology/Immunology at the University of Wisconsin Medical School and an infectious disease specialist at University of Wisconsin Hospital and Clinics, has been awarded the Alexander von Humboldt senior research award. Germany's top honor to eminent non-German scientists, the award carries a $55,000 stipend, an opportunity to meet with the German president, and an invitation to spend a year conducting research at a German university. Dr Proctor received his medical degree from the University of Michigan Medical School in 1970. Following an internship at UW Hospital and Clinics, he completed residency training at Georgetown University.

***Thomas Screnock, MD,** will be joining the Physician's Clinic of the Osseo Area Hospital on January 3, 1995. He received his medical degree at the Universityof Wisconsin-Madison, and did post-graduate work at the St. Paul Ramsey Hospital in St. Paul.

Mark your calendar!

NOW IS YOUR CHANCE to influence the political process! The SMS Legislative Day will be on Tuesday, March 14, 1995 at 9 AM at the Concourse Hotel in Madison. This is your chance to ensure elected representatives hear firsthand Wisconsin physicians' concerns regarding: The need for tort reform; relief from Wisconsin's inadequate Medicaid reimbursement; the expense of bureaucratic paperwork hassles, etc... The morning session will include remarks from powerful state leaders. After lunch, you will meet with your own elected representatives to discuss these and other important issues. Contact SMS Government Relations at 1-800-362-9080 to register.❖

Mark Simms, MD, MPH, has been appointed associate professor of pediatrics at the Medical College of Wisconsin. A specialist in child development and rehabilitation services and an expert on the medical issues of foster care, he will practice at Children's Hospital of Wisconsin. Prior to his appointment, he served as associate clinical professor of pediatrics at Yale University School of Medicine and adjunct associate professor of pediatrics at Dartmouth Medical School in New Haven, Conn. Dr Simms completed his fellowship in child rehabilitation and development at Children's Hospital of Philadelphia and his residency in pediatrics at Montefiore Hospital in the Bronx, NY. Dr Simms received his Master of Public Health degree from the Johns Hopkins University School of Hygiene and Public Health in Baltimore and his MD degree from State University of New York (SUNY) Upstate Medical Center in Syracuse.

***Craig Siverhus, MD,** has established his practice specializing in general and vascular surgery at 2015 E. Newport Avenue, Milwaukee.

Reeta Thukral, MD, has joined La Salle Clinic as a nephrologist. She had practiced medicine privately in Kenner, La., and was also chief of staff of St. Jude Medical Center, Kenner.

State Representative Frank H. Urban, MD, of Brookfield, received an Award of Distinction from the American Heart Association of Wisconsin at its annual volunteer awards reception in Pewaukee on October 26. A bill he authored to ban the sale of single cigarettes became law last April. He is also responsible for a law that requires cigarette vending machines to be in view of employees to reduce illegal sales to minors. As the only physician in the state legislature, Dr Urban has worked with the American Heart Association and the Tobacco-Free Wisconsin Coalition to educate legislators about the hazards of tobacco use.

***Michael P. Vrabec, MD, FACS,** has joined the ophthalmology practice of Valley Eye Associates in Appleton, Wisconsin. Dr Vrabec is board certified in ophthalmology. He graduated from the University of Wisconsin Medical School and completed his residency in ophthalmology at the University of Wisconsin with fellowship training in corneal transplantation at the University of Iowa and refractive surgery at the Hunkeler Eye Clinic of Kansas City, Missouri. He served as an associate professor of ophthalmology at the University of Vermont prior to moving to Appleton.

James N. Warren, Jr., MD, has joined the Mercy Health System, providing physical medicine and rehabilitation services to Janesville area patients. A native of Brooklyn, NY, Dr Warren received his medical degree from Temple University in Philadelphia, PA, and continued his training at Thomas Jefferson University Hospital, where he completed a three-year residency in internal medicine. Dr Warren is currently completing an intensive fellowship in physical medicine and rehabilitation at the University of Minnesota.❖

County society news

Brown. The Brown County Medical Society met Nov 10, 1994, at the Embassy Suites in Green Bay. The speaker was John Eversman, MD, Associate Director of Clinical Affairs, Medical College of Wisconsin. New members accepted into the society are: Dale Rustad, MD; Daniel Linehan, MD; C. John Abcan, MD; Kakan Naha, MD; and Mark Laukka, MD.

Fond du Lac. Dr Lars G. Ostman, MD, has been approved for membership in the Fond du Lac County Medical Society.

Green. The Green County Medical Society approved membership for Anthony Rogerson, MD; James Link, MD; Lester Nider, MD; and Peter Szachnowski, MD.

Green Lake-Waushara. Anthony Racki, MD, has been accepted as a member of the Green Lake-Waushara County Medical Society.

Marathon. The following physicians were accepted into the Marathon County Medical Society Nov 7, 1994: Fred D. Stahmann, MD; and Scott D. Howells, MD.

Marinette-Florence. Robert D. Merrill, MD; and Virginia M.S. Vallalon, MD, have been approved for membership in the Marinette-Florence County Medical Society.

Monroe. Howard D. Schumaker, MD, has been approved for membership in the Monroe County Medical Society.

Oneida-Vilas. The Oneida-Vilas County Medical Society meeting was held Oct 5, 1994 at Tula's in Eagle River. The speaker was Dr Richard Roberts, president of the SMS, and his topic of discussion was gun safety

Continued on page 652

Obituaries

Bitter, Reuben H., MD, died Aug 17, 1994, in Wild Rose. He was born Oct 28, 1895. He received his medical degree from Marquette University in 1922, and served his internship at Mercy Hospital in Oshkosh. Dr Bitter served in the armed forces from 1941-1946. He served on the medical staff of Mercy Medical Center and as medical director of Winnebago County Institutions. He was also attending physician at Sunny View Sanitorium in Winnebago from 1923 to 1932. Dr Bitter was a member of the Winnebago County Medical Society, the State Medical Society, and the American Medical Association. He is survived by two great nephews; and three great nieces.

Handeyside, Robert G., MD, died Aug 29, 1994, in Fort Atkinson. He was born Dec 29, 1921. He graduated from Marquette University and served his surgical residency at Milwaukee Hospital. He was a lieutenant in the US Navy. Dr Handeyside began his medical practice in Paymyra in 1949. During his affiliation with Fort Atkinson Memorial Hospital, he served as chief of surgery and chief of staff. He was a member of the hospital's executive committee and served as the medical staff's representative to the board of directors. He was a Diplomate and Fellow of the American Academy of General Practice and the American Academy of Family Physicians. He served as president of the Marquette University Medical School Alumni Association. Dr Handeyside is survived by two sons, Robert of Frankenmuth, Mich, and Thomas of Phoenix, Ariz; three daughters, Mary Hartenian of Manitowoc, Martha of Madrid, Spain, and H. Kate Nehmer of Fort Atkinson; a brother; a sister; and six grandchildren.

Janssen, William Charles, MD, died Sept 9, 1994. He was born Aug 18, 1925. He graduated from Marquette University Medical School in 1954, and completed his internship and residency at Columbia Hospital in Milwaukee. Dr Janssen was director of clinical research, Lakeside Laboratories in Milwaukee until 1975. He later practiced with the Allergy Clinic of Milwaukee and retired in 1993. He is survived by his wife, Joan; his sons, William C. Janssen, Jr., Palo Alto, Calif, Dr. Peter G. Janssen, Middleton; and two daughters, Margaret Janssen-Brown, Boulder, Colo, and Virginia Janssen-Gallus, Green Bay; and a granddaughter.

Kniaz, Albert, MD, died Aug 29, 1994 in Glendale. He was born May 30, 1922. He graduated from the University of Lausanne, Switzerland, in June 1956. He served his internship at the Milwaukee Ev. Deaconess, and his residency at Milwaukee County Hospital for Mental Diseases. Dr Kniaz was the medical director of the St. Michael Hospital Mental Health Center in Milwaukee.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.❖

Oelhafen, Col. Wayne R., MD, died Sept 18, 1994, in Rhinelander. He was born Oct 20, 1919 in Tomahawk. He graduated from the Medical School of Wisconsin in 1944. He served in the US Army until retiring from the service in 1963. He served in World War II, the Korean War and Vietnam. He served as the surgeon general for the 7th division during the Korean War. Dr Oehlafen received the Bernard Varuch Fellowship in Medicine award from the Mayo Clinic, was on the faculty of the Medical Service School in San Antonio, Texas, and was a member of the American Congress of Physicians. He is survived by two sisters, nieces and nephews.

Olson, Lester J., MD, died on Aug 25, 1994. He received his medical degree from the University of Minnesota in June 1943, after serving an internship at Brooke General Hospital, Fort Sam Houston, Texas. He served in the US Army from 1943 to 1946, in the ETO, 301 Medical Battalion of the 76th division. Upon discharge from the army, Dr Olson opened a practice in Spooner, where he stayed until his retirement in 1980. He died in the Spooner Memorial

Hospital where he had worked so diligently to establish the current complex. He is survived by his wife, Jeannette, two sons, Jon and Gregory, and daughter, Susan Olson Jackson.

Pawlisch, Otto V., MD, died Aug 3, 1994. Dr Pawlisch received his medical degree from the University of Illinois. He practiced medicine at the Reedsburg Memorial Hospital for more than 50 years, retiring in 1982. He also served as the Sauk County Coroner. Dr Pawlisch was a member of the Sauk County Medical Society, The State Medical Society and the American Medical Association. He is survived by his sons, Carl O. Pawlish of LaValle, Dr James T. Pawlisch of Reedsburg, and Dr Paul Pawlisch of Whitefish Bay; and by five grandchildren and five great-grandchildren.

Simenson, Raymond S., MD, died Sept 5, 1994. He was born Nov 17, 1906. He received his medical degree from the University of Wisconsin, Madison. He began practice in Valders in the early 1930s. He served in the US Army, and continued his practice in Manitowoc until the early 1950s. Dr Simenson moved to Appleton and practiced medicine until his retirement in 1984. Survivors include his wife, Violet; two daughters, Karen Kurtz, Bayfield, Colo, and Barbara Lewis, Albuquerque, NM; and a sister.❖

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Continued from page 649
among children. The following physicians were approved for membership: Kurt Landauer, MD; John Kozisek, MD; Matthew M. Drewry, MD; Margaret Abel, MD; Michelle Cihla, MD; Gary Dier, MD; and Anne Drewry, MD.

Outagamie. The following physicians were approved for membership in the Outagamie County Medical Society: William Gustafson, MD; Jill P. Harman, MD; Steven L. Kagen, MD; John E. Kirkpatrick, MD; Robert M. Makeever, MD; Diane M. Mayland, MD; and Michael P. Vrabec, MD.

Racine. Ronald L. Allen, MD, has been approved for membership in the Racine County Medical Society.

Sauk. The following physicians have been approved for membership in the Sauk County Medical Society: Scott Ehman, MD; Mark Meier, MD; Karen Ailsworth, MD; Craig Maskil, MD; and Naeem Jahirkheli, MD.

Shawano. Michael J. Michalske, MD, and John R. Spencer, MD, were elected to membership in the Shawano County Medical Society.

Winnebago. The following physicians have been approved for membership in the Winnebago County Medical Society: Timothy Seline, MD; Michael Pech, MD; David Finch, MD; Ward Jankus, MD; Nora Rowley, MD; Edward Ford, MD; Robert Bechard,MD; Stephen Brink, MD; Jeffrey Burkett, MD; Allison Martin, MD; and Susan Szabo, MD.

Wood. The Wood County Medical Society approved membership for the following physicians: Timothy Boyle, MD; Kamilla Buddemeier, MD; Amy Camacho, MD; Patrick Chen, MD; Margo Cousins, MD; Frank DeStefano, MD; Tom Faciszewski, MD; David Heegeman, MD; James Lee, MD; Karen Mielke, MD; Thomas Nelson, MD; Shereif Rezkalla, MD; Roxann Rokey, MD; Loren Rolak, MD; Maria Romanenko, MD; Ann Smith, MD; Gwen Stone, MD; Jaye Sticker, MD; Patrick Sullivan, MD; Timothy Swan, MD; Wayne Thorne, MD; and Andrew Urquhart, MD.❖

The Wisconsin Senior Physician's Association enjoying their fall annual meeting in Door County.

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

October, 1994

Arif, Abdul O.
Blackmer, Franklin H.
* Bolger, John T.
* Burko, Henry
* Dicus, William T.
* Gunsolly, Brent L.
* Hardacre, Jerry M.
* Hathway, Stephen D.
* Lemon, Richard A.
* Luther, Dennis M.
* Nassiff, Marie D.
* Rokey, Roxann
* Thomason, Jessica L.
Torres, Roger Ven Soriano❖

TODAY'S THE DAY
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American Heart Association

Index to articles: 1994

Key to numbering. The first number in the issue number (eg, January is 1,February is 2, etc.) The second number is the page number. The numbering of pages are continuous beginning with the January issue. All issues are Vol 93.

Authors of scientific articles.
(All authors are MDs unless otherwise noted.)

Akansel, Gur, Milwaukee:9-470
Aprahamian, Charles, Milwaukee:4-165
Aronson, Richard A., Madison:6-257;8-415

Blackwelder, Mary, MLS, Milwaukee:4-159
Blackwell, Barry, Milwaukee:2-51
Brooks, Lori L., Milwaukee:1-16
Brummond, Ruth A., RDMS, Milwaukee:9-467

Chelmowski, Mark, Milwaukee:12-623
Collier, David, Milwaukee:9-470

DeBehnke, Daniel J., Milwaukee:4-165
Dewire, Douglas M., Milwaukee:3-107
Duthie, Edmund H., Jr., Milwaukee:1-16

Eckstam, Eugene, Monroe:6-266
Elejalde, B. Rafael, Brown Deer:2-51

Farley, George E., Milwaukee:4-169
Farrell, Philip M., Madison:8-415
Fifield, Dan H., Wild Rose:2-55
Fischer, Virginia, MS, Marshfield:12-627

Gundersen, Jerome H., La Crosse:2-58
Gunderson, Paul, PhD, Marshfield:12-627

Hamberger, L. Kevin, PhD, Milwaukee:12-623
Hamsher, Kerry de S., Milwaukee:2-51
Hardie, Robert C., Milwaukee:12-621
Hargarten, Stephen W., Milwaukee
Hayes, John, Marshfield:8-426
Hendee, William R., PhD, Milwaukee:4-159
Hepp, Holly, RN, Milwaukee:4-165
Hoffman, Gary, MS, Madison:8-415

Isitman, Ali Tan, Milwaukee:9-470

Katcher, Murray L., Milwaukee:10-511,515
Kolindou, Anna, Milwaukee:9-470
Kraklow, William, Milwaukee:5-212
Kranendonk, Donald H., Wausau:3-109
Krasnow, Arthur Z., Milwaukee:9-470

Laessig, Ronald H., PhD, Madison:8-415
Lalich, Roger A., DO, Waukesha:8-422
Lamb, Geoffrey, Milwaukee:5-212
Lappe, Karen, RN, BSN, Marshfield:12-627
Lawrence, Sarah W., RN, Milwaukee:4-165
Lawson, Russell K., Milwaukee:3-107
Lebel, Robert R., Elmhurst:2-51

Mayersak, J.S., Wausau:1-13
McAuliffe, Timothy L., PhD, Milwaukee:5-207
Meyer, Margaret M., RNC, MS, Waukesha:8-422
Meyer, Matthew A., Waukesha:8-422

Nashold, R.D., PhD, Madison:10-525
Nichols, Sheila, La Crosse:2-58

O'Brien, Mallory, MS:10-521

Raikar, Sharmishtha, Marshfield:6-261
Reding, Douglas J., Marshfield:12-627
Redlich, Philip N., Milwaukee:5-207
Reith, Kathy L., RRA, CTR, Milwaukee:5-207
Reynolds, Norman C., Milwaukee:2-51
Rezkalla, Shereif, Marshfield:6-261
Robinson, Lisa A., RRA, Milwaukee:5-207

Shah, Prakash, Milwaukee:5-212
Sty, John R., Milwaukee:9-467;12-621

Tellier, Laurie, MS, RN:6-257
Tyre, Emily M., Ohio:1-9
Tyre, Timothy E., PhD, Waukesha:1-9

Urlakis, Mary Anne, BS, Milwaukee:4-159
Uygur, Gulay A., Milwaukee:9-470

Valley, Verena T., Milwaukee:4-165
Viviano, Carl J., Wausau:1-13

Wagner, Marvin, Milwaukee:4-169
Walworth, Diane E., RN, Waukesha:1-9
Watts, David T., Madison:5-203
Wells, Robert G., Milwaukee:9-467;12-621
Wertsch, Jacqueline J., Milwaukee:1-16
Widener, Judy, RN, Waukesha:8-422
Winter, Gregory R., Milwaukee:2-51
Wirtz, Charles E., Marshfield:8-426

Authors of non-scientific articles.

(All authors are MDs unless otherwise noted.)

Adler, Robert, MS, Madison:9-480
Alles, Peter J., MPA, Madison:8-433
Anderson, Henry, Madison:2-63
Aronson, Richard, Madison:5-217

Barber, Karen, Elkhorn:9-473
Brindley, Marge S., MS, Milwaukee:11-582
Bush, Darren, MA, Madison:1-21;5-217;9-480;9-483

Cardell, April, Madison:1-21
Chudy, Nancy E., MPH, Madison:4-173;10-531
Cismoski, Joseph, MPH, Fond du Lac:11-585,591

Edwards, Richard W., Richland Center:12-639

Gifford, Robert, Milwaukee:11-582
Goeckermann, Cheryl R., Milwaukee:9-473
Gold, Jay A., Madison:5-219
Goldring, Jay, PhD, Madison:2-63;8-441

Hamberger, L. Kevin, PhD, Milwaukee:9-473
Hanrahan, Lawrence, PhD, MS, Madison:2-63
Haskins, Linda, Madison:1-21
Haupert, Terry, BS, Green Bay:8-441
Henls-Lowe, Barbara, MHP, Madison:1-21
Herzog, Stacy, BS, Madison:9-480
Heuer, Barbara D., RN, Madison:5-219
Hoover, Norman W., Milwaukee:8-429

Ingalls, Jerry M., Madison:8-433

Katayama, Alyce C., Milwaukee:8-438;12-631
Kvale, Katherine M., PhD., Madison:6-275

Lantz, Paula M., PhD, Madison:6-275
Latton, Susan, Madison:5-217
Lyons, Lisa A., Milwaukee:12-631

Maigaard, Randy, Milwaukee:6-271
Moberg, Paul, PhD, Madison:8-444

Nashold, Ray, PhD, Madison:10-531
Nordstrom, David L., MS, Marshfield:12-636

Phillips, Jerri Linn, MA, CTR, Madison:9-483

Reeves, Mathew, BVSc, PhD, Atlanta:9-480;9-483
Remington, Patrick L., Madison:1-21;2-63;3-125;4-173;5-217;6-275;9-480;9-483;10-531;11-569

Scheckler, William E., Madison:8-444
Schiedermayer, David, Milwaukee:6-271
Schulz, Rockwell, PhD, Madison:8-444
Selkurt, Joanne, Whitehall:1-29
Sheridan, Marian, RN, Fond du Lac:11-585
Stoll, Rick, BS, Green Bay:8-441

Utech, Susan, MS, CHES, Madison:5-217

Van Gilder, Thomas J., Madison:11-569

Wencel, Sally L., JD, Madison:8-433
Wood, Susan, Madison:1-21

Yoast, Richard A., PhD, Madison:11-578

Zvara, Judith, Madison:1-21

Scientific articles, abstracts and information

Adrenal hyperchogenicity in hemolytic uremic syndrome (Wells,Sty,Brummond):9-467
AIDS: Sonography of hyperechonic renal pyramids in renal candidiasis (Sty,Wells,Hardie):12-621
Breast milk: Should mothers be routinely screened?, Lead in (Tellier,Aronson):6-257
Cancer at the time of diagnosis, Trends in the stage of (Redlich,McAuliffe,Robinson,Reith):5-207
Chronic pain patients 4 years after multidisciplinary care, The outcome status of (Tyre,Walworth,Tyre):1-9
Coumadin toxicity, Unusual complication of (Shah,Kraklow,Lamb):5-212
DNA testing and genetic counseling: truth or consequences (Reynolds,Lebel,Hamsher,Blackwell, Elejalde,Winter):2-51
Domestic violence in your medical practice, screening men for (Chelmowski,Hamberger):12-623
Elderly, Use of devices for mobility by the (Brooks,Wertsch,Duthie):1-16
Firearm deaths in Wisconsin: an analysis for examining prevention strategies, Trends in motor vehicle and (Hargarten,O'Brien):10-521
Firearm injuries among children and adolescents: I. The Facts (Katcher):10-511
Firearm injuries among children and adolescents: II. The physician's role in prevention (Katcher):10-515
Firearm mortality trends in Wisconsin (Nashold):10-525
Geriatric trauma in southeastern Wisconsin, A profile of (Valley,Hepp,DeBehnke,Lawrence, Aprahamian):4-165
Health education delivery by Wisconsin veterinarians (Reding,Fischer,Lappe,Gunderson):12-627
Health Information Technology Center at the Medical College of Wisconsin, The (Hendee,Urlakis, Blackwelder):4-159

HIV, The surgeon, needle-sticks, and (Kranendonk):3-109
Incarcerated hernia with intestinal obstruction after laparoscopic cholecystectomy (Wagner,Farley):4-169
LEEP: Early experience with a new approach to cervical lesions (Gundersen,Nichols):2-58
Mobitz Type II heart block presenting as weight loss (Wirtz,Hayes):8-426
Newborn screening for cystic fibrosis in Wisconsin: first application of population-based molecular (Farrell,Aronson,Hoffman):8-415
Outcomes of resuscitative efforts at Wild Rose Hospital (Fifield):2-55
Pancreatectomy for ductal adenocarcinoma of the head of the pancreas, Survival 13 years after (Eckstam):6-266
Pedal radiocolloid lymphoscintigraphy in demonstration of a post-surgical lymphatic leak (Uygur,Akansel,Kolindou,Isitman,Krasnow,Collier):9-470
Takayasu's arteritis: a report of three cases (Raikar,Rezkalla):6-261
Vaginal contraceptive suppository into the urinary bladder, Transurethral insertion of a (Mayersak,Viviano):1-13
Vaginal hysterectomy in a community hospital, Outpatient (Meyer,Lalich,Meyer,Widener):8-422
Vasectomy reversal at the Medical College of Wisconsin, Experience with macroscopic (Dewire, Lawson):3-107
Vitamin B_{12} replacement therapy: how much is enough? (Watts):5-203
Wisconsin Primary Care Research Forum, Proceedings of the 1993:3-113

Socioeconomic and ancillary articles

Abortions to state, Medical facilities must report information about: 12-640
AMA compiles "railroad Medicare" complaints:5-222
AMA unveils legislative initiative to protect patients:6-277
Arsenic in private drinking water wells in Outagamie and Winnebago counties, Wisconsin, Public Health(Goldring,Haupert,Stoll):8-441
Asthma hospitalizations in Wisconsin: public health implications (Goldring,Hanrahan,Anderson):2-63
Business seminar scheduled for Wisconsin physicians:2-74
Cancer Control Program, The Wisconsin Women's, Public Health (Remington,Hasking,Zvara,Henls-Lowe;Bush;Cardell,Wood):1-21
Cardiovascular risk factors among diabetics and non-diabetics in Wisconsin, Public Health (Remington, Chudy):4-173
Cigarettes on Wisconsin communities, 1994, The health care burden of (Van Gilder,Remington):11-569
Clarifying goals, improving communication, and finding joy in the doctor-patient relationship (Maigaard,Schiedermayer):6-271
Death in Wisconsin, Preventable causes of, Public Health (Remington):3-125
Domestic violence unique to rural areas, Issues of (Goeckermann,Hamberger,Barber):9-473
Epidemiology of osteoarthritis (Nordstrom):12-636
Firearm injury surveillance system, The Wisconsin, Public Health (Remington,Chudy,Nashold):10-531
Fraud and abuse safe harbors, New (Katayama):8-438
Good Samaritan bill, Thompson signs:1-26
HMOs in Dane County: 1983-1993, Physician satisfaction with the development of (Scheckler, Schulz,Moberg):8-444
In situ breast cancer: A local area analysis of Dane County, Wisconsin, Public Health, (Herzog,Bush, Remington,Reeves,Adler):9-480
In situ breast cancer correlates with mammography use, Wisconsin:1980-1992 (Bush,Remington,Reeves, Phillips):9-483
Liability protection, The use of practice guidelines in Wisconsin for:2-69
Medical Examining Board elects officers:2-72
Medical Outcomes Research Project, The SMS-CESF (Ingalls,Wencel,Alles):8-433
Papanicolaou smear tests among women after hysterectomy, Self-reporting of, Public Health (Kvale,Remington,Lantz):6-275
PIC Wisconsin: Continued commitment to physicians (Edwards):12-639
Public Health
- The Wisconsin Women's Cancer Control Program (Remington,Hasking,Zvara,Henls-Lowe; Bush,Cardell,Wood):1-21
- Asthma hospitalizations in Wisconsin: public health implications (Goldring,Hanrahan,Anderson):2-63
- Preventable causes of death in Wisconsin (Remington):3-125
- Self-reported cardiovascular risk factors among diabetics and non-diabetics in Wisconsin (Remington,Chudy):4-173
- Regional differences in smoking rates among women giving birth in Wisconsin, 1990-1992 (Remington):5-217
- Self-reporting of Papanicolaou smear tests among women after hysterectomy (Kvale,Remington, Lantz):6-275
- Aresenic in private drinking water wells in Outagamie and Winnebago counties, Wisconsin

(Goldring,Haupert,Stoll):8-441
- In situ breast cancer: A local area analysis of Dane County, Wisconsin (Herzog,Bush,Remington, Reeves,Adler):9-480
- In situ breast cancer correlates with mammography use, Wisconsin: 1980-1992 (Bush,Remington, Reeves,Phillips):9-483
- The Wisconsin firearm injury surveillance system (Remington,Chudy,Nashold):10-531
- The health care burden of cigarettes on Wisconsin communities, 1994 (Van Gilder,Remington):11-569
- Epidemiology of osteoarthritis (Nordstrom, MS):12-636

Quality of care: Joining forces to define it (Hoover):8-429
Service corporation bill, Legislators to introduce:1-27
Smoking in an average Wisconsin community, The daily burden of (Yoast):11-578
Smoking rates among women giving birth in Wisconsin, 1990-1992, Regional differences, Public Health (Remington):5-217
Stark realities: Coping with federal and state self-referral paranoia (Katayama,Lyons):12-631
Tobacco acquisition practices of adolescents in two Wisconsin communities (Cismoski,Sheridan):11-585
Tobacco control policies, Attitudes of the Wisconsin State Legislature toward (Gifford,Brindley):11-582
Tobacco possession laws against minors, Blinded by the light: The folly of (Cismoski):11-591
Tobacco use?, Is your waiting room reading material promoting:11-573
Wisconsin peer review, The health care quality improvement program (Gold,Heuer):5-219
Wisconsin physician named to national health post:2-68

State Medical Society - Organizational

A glimpse into our past (Sautter):6-279;9-487
Accreditation program for continuing medical education:7-350
Adams, Thomas L., EVP Report:1-4;2-44;3-101;4-156;5-196;6-246;7-298;8-408;9-464;10-504;11-561;12-616
- Is anybody listening?
- The value of a Wisconsin physician defense "association"
- Taking measure of the new AMA
- This is no time to turn and run
- Making the SMS world a little bit safer
- Addressing some issues raised by our recent survey
- Peeling onions under the summer sun
- Stumbling in the dark
- The sun also rises
- An ounce of prevention is worth a pound of government
- Neither Rome nor the SMS was built in a day
- At the heart of medicine lies the heart of humanity

AMA advisory committee, Ulmer, Newcomer to serve on:2-83
AMA advisory group, Kirby appointed to:5-230
AMA awards:5-228;9-493;11-606;12-652
AMA candidate Tim Flaherty, MD, tackles issues facing physicians (Hamilton):3-129AMA compiles "railroad Medicare" complaints:5-222
AMA seeks recommendations for committee appointments:11-601
Annual meeting
- 1994 House actions on resolutions and reports:7-369
- House of Delegates Nominating Committee: 1994-1995:7-373
- Presidential address, A great flame follows a little spark (Jackson):7-374
- Address of the president elect, Children, gun violence and the healing community: Wisconsin physicians together making the difference (Roberts):7-375
- EVP report to the House of Delegates, Crazy times demand crazy organizations (Adams):7-378
- Awards given by the SMS in 1994:7-381
- Reference committees: 1994:7-384
- Annual meeting resolutions due:12-647

Annual meeting resolutions are due Feb 11:1-30
Blue Cross lawsuit, SMS Executive Committee calls for withdrawal of:3-137
Book review, The Life and Times of a Country Doctor (Hamilton):2-81
Book review, Out of Dr Bill's Black Bag: From Northern Wisconsin a Country Doctor Looks Back (King):3-136
Call for papers, A:4-188
CES Foundation donors:3-144;10-547
CESF Foundation
- A CESF guide to gifts:7-386
- CESF facts:7-387
- CESF history:7-388
- Foundation grant allocation:7-389
- The Fort Crawford Medical Museum:7-390
- CESF Foundation awards two research grants:12-645

Charitable giving through the PIC-Wisconsin matching grant program, Making the most of your:11-606
Charter law of the SMS:7-358
CHILD SAFE questions:10-539
CHILD SAFE health initiative to reduce firearm injuries, deaths among children, teens, SMS kicks off statewide (Hamilton):10-535
Constitutional amendment, Notice to members of

proposed:1-30
Constitution and Bylaws:7-359
County society news:2-84;3-142;5-233;6-283;7-395;8-454;9-491;10-545;11-604;12-651
- Ashland-Bayfield-Iron:11-604
- Brown:2-84;6-283;10-545;12-651
- Chippewa:10-545
- Clark:10-545
- Columbia-Marquette-Adams:11-604
- Dane:2-84;3-142;5-233;6-283;7-395;8-454;10-545;11-604
- Dodge:11-604
- Door-Kewaunee:11-604
- Douglas:11-604
- Eau Claire-Dunn-Pepin:2-84;3-142
- Fond du Lac:2-84;3-142;5-233;7-395;11-604;12-651
- Grant:2-84;9-491
- Green:12-651
- Green Lake-Waushara:2-84;8-454;10-546;12-651
- Jefferson:2-84;10-546
- Kenosha:2-85;6-283;10-546
- LaCrosse:3-142;9-491;11-604
- Langlade:3-142
- Marathon:3-142;5-233;6-283;9-491;12-651
- Marinette-Florence:2-85;12-651
- Milwaukee:2-85;5-233;6-283;8-454;9-491;11-604
- Monroe:6-283;12-651
- Oneida-Vilas:2-86;5-234;7-395;12-651
- Outagamie:6-283;10-546;12-651
- Ozaukee:2-86;5-234;11-605
- Pierce-St. Croix:5-234
- Price:3-142
- Racine:2-86;3-142;5-234;10-546;12-651
- Richland:2-86;3-142;6-283;9-491
- Rock:2-86;3-142;5-234;11-605
- Sauk:2-86;3-142;12-651
- Sawyer:10-546
- Shawano:12-651
- Sheboygan:2-86;5-234;10-546
- Taylor:2-86;10-546
- Trempealeau-Jackson-Buffalo:11-605
- Walworth:8-454;10-546
- Washington:7-395;11-605
- Waukesha:2-86;3-142;5-234;6-283;10-546;11-605
- Waupaca:2-86
- Winnebago:2-86;6-283;10-546;12-651
- Wood:9-491;12-651
Dates for 1994, Reserve these:1-29
Domestic violence, SMS annual meeting program on:2-80
Domestic violence, SMS Board of Directors approves policy on reporting of:4-178
Domestic abuse, model protocol, The assessment and treatment of:4-178
Editorials: 5-198;10-506;11-563
- Percentages must go (Lewis):5-198
- Primary care and nurses (Sautter):5-198
- A clarification of WMJ policy (Sautter):10-506
- Primary care and nurses (Sautter):11-563
Electronic bulletin board system, Survey to determine interest in SMS:2-80
Electronic claims network, SMS enters agreement with:5-231
Expense reimbursement policy and procedure for physicians on SMS business:7-356
Gun injuries, Are Wisconsin kids really at risk for:10-538
Gun safety checklist:10-541
Gun safety initiative, Rock County physicians seize (McCollum):10-537
Gun violence, SMS board approves plan for joint conference on:8-449
Health system reform, Wisconsin delegation joins unity demonstration on:4-177
Health system reform, SMS issues call to action on:8-447
HIV, nicotine released, New guidelines on:2-87
Letters:1-6,7;2-48,50;3-102,103;5-200,201;6-253;7-300;8-410,412;11-564,565,566;12-617
- Support for generalist track in medical school (Jensen)
- Medicine ruled by the whims of tyranny (Fogarty)
- WIPRO petition draws fire (Gay)
- Food for thought (Cameron)
- Health care, rights and the Wizard of Oz (Correll)
- WMJ article on carpal tunnel release inspires discussion (Siegert)
- Recruiting effort draws fire (Kloster)
- Reform must fill the Medicare gaps (Elfton)
- Lyme disease and Hippocrates (Reske)
- AMA recruiting effort draws more fire (Smith)
- And still more (Rengel)
- Kudos for the new president (Hammer)
- An added resolution (Lewis)
- WMJ article on surgeons and HIV prompts concern (Gessert,Brennam)
- Physician petition leads to changes at WIPRO (Kief,Simmons)
- Joy is the only perfection (Lewin-Fetter)
- We need both enthusiasm and wisdom (Bauer)
- The physician is sick (Chelius)
- Comments of the CHILD SAFE program (Walz)
- Friend or foe? (Koons)
- The costs of poor choices (Schultz)
Mediation and peer review services:7-349
Medical liability, SMS commission to sponsor program on:2-85
Medical student program sponsors sought:2-86

Medical students hear of need for involvement:11-602
Membership fact:7-351
Mike²: A potent formula for organized medicine (Hamilton):5-225
Mini-internships, Racine, Milwaukee, and Rock counties hold:2-87
Mini internship report: Creating new and stronger allies (Hamilton):12-641
MinnesotaCare challenge, Court reinstates:8-450
Nominating Committee compiles slate of candidates; Dr Ulmer nominated for 1995 president elect:11-601
Nurse prescribing rules, SMS requests hearing on:11-605
Obituaries:2-88;3-145;4-186;5-235;7-395;8-455;9-492;12-650
- Allin, Robert Nail, Madison:9-492
- Anderson, John M., Madison:4-186
- Bachhuber, Max O., Alma:7-395
- Balder, Roy B., Jr., Hillsboro:5-235
- Bauer, Carroll A., West Bend:4-186
- Benjamin, Hiram B., Milwaukee:3-145
- Bitter, Reuben H., Wild Rose:12-650
- Bonner, Joseph N., N. Fort Myers, Fla.:2-88
- Bortin, Mortimer M., Milwaukee:9-492
- Brah, William A., Mequon:3-145
- Caffrey, James F., Green Bay:2-88
- Cohen, Philip P., Portland, Ore.:2-88
- Culver, John R., Oconto Falls:3-146
- Cupery, Dowe P., Markesan:7-395
- Dorr, Robert H., Cedarburg:3-146
- Dunst, Carl G., Milwaukee:2-88
- Fifrick, Lloyd L., Milwaukee:4-187
- Fine, Jacob M., Milwaukee:2-88
- Freuhauf, Richard P., Superior:3-146
- Hacker, Louis C., Marshfield:5-235
- Halser, Joseph G., Milwaukee:5-235
- Handeyside, Robert G., Fort Atkinson:12-650
- Hirschboeck, John S., Milwaukee:3-146
- House, Jerome W., Jr., Milwaukee:2-89
- Hoyer, John K., Marshfield:9-492
- Huebner,Jewel Steiner, Oshkosh:2-89
- Jachowicz, Robert B., Milwaukee:5-236
- Jackson, C. Robert:8-455
- Jansen, Ruth L., Milwaukee:5-236
- Janssen, William Charles, Milwaukee:12-650
- Johnson, John M., Oconomowoc:7-396
- Johnson, Ronald C., Boca Raton, Fl.:2-89
- Kniaz, Albert, Glendale:12-650
- Kustermann, Alois F., Milwaukee:2-89
- Lakritz, Leo W., Beloit:7-396
- Lennon, Edward J., Milwaukee:3-146
- Logemann, Ronald L., Shawano:2-90
- McNamee, James R., Boscobel:4-187
- Miller, Joseph F., Madison:4-187
- Milliken, Lyle David, Kenosha:2-90
- Nimz, Robert A., Milwaukee:3-147
- Oelhafen, Col. Wayne R., Rhinelander:12-650
- Olson, Lester J., Spooner:12-650
- Pawlisch, Otto V., Reedsburg:12-650
- Peckham, Ben M., Madison:9-492
- Peterson, Marvin G., Brookfield:4-188
- Polacheck, Walter S., Shorewood:7-396
- Reyes, Cesar N., Jr., Marshfield:5-236
- Rudman, Daniel, Wauwatosa:8-396
- Saladar, Rafael S., Rockford, Ill.:5-236
- Sanfelippo, Anthony J., San Deigo:7-396
- Sattler, Chester A., Kenosha:5-236
- Scheunemann, Wallace E., Milwaukee:7-396
- Schroeder, Charles Morrison, Milwaukee:7-396
- Schubert, Edward F., Stevens Point:8-455
- Simenson, Raymond S., Appleton:12-650
- Sroka, William Charles:9-493
- Steffen, Elizabeth Allen, Milwaukee:3-147
- Stoerker, Ruth A., Madison:3-147
- Struthers, James L., Marshfield:2-90
- Taborsky, Charles R., Madison:3-148
- Temple, Robert L., Wood:5-236
- Tonkens, Samuel W., Milwaukee:3-148
- Wisler, Robert J., Milwaukee:5-236
- Yatso, Michael G., Milwaukee:7-397
- Zintek, Arthur R., Milwaukee:2-90

Offices of Wisconsin's county medical societies:7-330
Officers of the SMS specialty and specialty sections:7-335
Officers of Wisconsin specialty societies:7-339
Physician briefs:1-32;2-82;3-140;4-185;5-230;6-282;7-394;8-450;10-543;11-602;12-647
Physician-Citizen of the Year award nominations, deadline nears:1-32
President's Page:1-3;2-43;3-99;4-155;5-195;6-245;7-295;8-405;9-461;10-501;11-557;12-613
- Chicken soup (Jackson)
- Physicians remain vital to the war on tobacco (Jackson)
- We have very good friends at 330 Lakeside (Jackson)
- We face the challenges together (Jackson)
- On making the difference (Roberts)
- Answering the call (Roberts)
- The rough riders of reform (Roberts)
- All aboard the ship of reform? (Due in DC means doin' DC)(Roberts)
- My campaign slogan: Politics is too important to be left to politicians (Roberts)
- The New Math: Kids + Guns = Dead (Roberts)
- Ciphering the new alphabet: Rx for APN (Roberts)
- A New Year's resolution for the new era's revolution: Leading change through a changing lead

(Roberts)
Publications available:7-342
Registration begins for special SMS PO/PHO seminar:9-488
Request for bids issued in Waukesha County:5-233
Smoke-free kids at state Capitol, Dr Roberts meets:4-183
SMS commission, New members appointed to restructured:6-281
SMS commissions and task forces: 1994-1995:7-321
SMS Executive Committee calls for withdrawal of Blue Cross lawsuit:3-137
SMS financial report:7-357
SMS headquarters gain new security system:7-393
SMS message to Washington, Dr Roberts carries:8-448
SMS offices: 1994-1995, Nominees for:2-77
SMS officers and directors: 1994-1995:7-303
SMS officers and directors by district:7-353
SMS physician support program:7-348
SMS president appointed to special legislative committee:9-487
SMS resource director:7-316
SMS shares Medicaid reimbursement concerns with state officials:9-491
Soundings:6-251;10-508,509;11-567;12-618
- Farewell to a friend: Morry Schroeder, MD, 1908-1994 (Boulanger):6-251
- The tragedy of gun violence (Bincer):10-508
- Guns and me (Hirsch):10-509
- Revenge (Kindschi):11-567
- Class reunion (Moskalewicz):12-618

Statewide Physician Health Program:7-345
Teen Workshop on Health brings safety message to Wisconsin kids:12-646
Teens and domestic violence, Special series (Selkurt):1-29
Terminal care in long-term care facilities and at home, SMS commission updates guidelines on:3-138
Transportation, SMS Board restructures Commission on Safe:3-138
Vaccine information forms needed after Oct 1, New:10-542
WIPRO encourages ideas for local improvement projects:10-543
WIPRO investigated:3-143
Wisconsin delegation carries resolutions to AMA:8-449
Wisconsin Medical Journal
- Instructions to authors:5-237;6-284;9-494
- Index to articles:12-653

WISPAC and Physicians for Better Government:7-346❖

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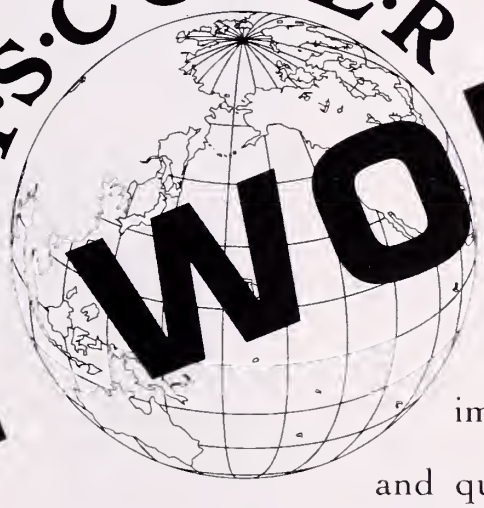

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- 25 owned/affiliated North Memorial clinics

Interested BC/BE MDs, send CV or call:
North Medical Programs
North Memorial Medical Center
3300 Oakdale Avenue North
Robbinsdale, MN 55422
800-275-4790

LOCUM TENENS

Do you need a physician for a temporary assignment?
or
Are you interested in a temporary assignment?

Wisconsin Physicians working in Wisconsin.

Dunhill Physician Search
1-800-334-6407

11-12/94-1/95

FAMILY PRACTICE PHYSICIAN needed to join established group of five FPs and one Pediatrician. Northwestern Wisconsin community of 8,000 with service area of 40,000, located on the doorstep of Wisconsin's fabulous lake country. Practice medicine in a small family-oriented community within two hours of Minneapolis/St. Paul. Competitive

WISCONSIN

Planned Parenthood of Wisconsin (PPW) is seeking a full-time Medical Director certified in OB/GYN or Family Practice. The candidate should be innovative, energetic, visionary, and committed to reproductive choice. The position provides the opportunity for strategic planning, academic and clinical involvement, administrative oversight of medical services, and a public presence in the promotion of reproductive choice and primary health care for women and families.

PPW is the largest Planned Parenthood in the nation providing health and education services statewide to over 102,000 clients in 40 clinics. In addition, PPW offers statewide sexuality education to communities and professionals. PPW also offers an accredited OB/GYN nurse practitioner program. The PPW corporate offices are located in downtown Milwaukee adjacent to Lake Michigan and within a 10 mile radius of two schools of medicine.

PPW offers a competitive salary and fringe benefits. Submit CVs or direct inquiries to Nancy M. Tabor, Senior Vice President Program Services, Planned Parenthood of Wisconsin, 302 N. Jackson St., Milwaukee, WI 53202. (414) 271-8045.

Physicians Exchange

Continued

salary and excellent fringe package. Send CV to James A. Volk, MD, Medical Director, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 8-12/94

THE WAUSAU MEDICAL CENTER is seeking Board Certified-Eligible individuals in the following specialties: Internal Medicine, Family Medicine, Obstetrics/Gynecology, Occupational Medicine and Urology. Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefit plan and profit sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year round. Write or call collect David K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Drive, Wausau, Wisconsin 54401, telephone (715) 847-3235. 2/93;TFN

Miscellaneous

State Medical Society of Wisconsin

Date and location of
1995 ANNUAL MEETING

April 7-9
Grand Geneva Resort & Spa

Further information: Call the SMS Meetings Department. Local Telephone: 257-6781; toll-free: 1-800-362-9080.

Miscellaneous

Hunting Club

Looking for two partners to join in purchase of private 200 acre hunting club located on Wolf River near Fremont. Property is heavily timbered bottomland with marshes and offers excellent duck and deer hunting. Legal IRA investment because land is in DNR forest program and will generate income when timber is harvested. Minimum $30,000 investment required, (414) 628-3438.

TFN 12/94

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Physician - Hospital Network Development
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- Practice Startup
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Over 15 years of experience, MBA, references

William Borchardt
707 Oak Hill Lane
Fort Atkinson, WI 53538
414/563-2504

Fellow, American College of Medical Practice Executives

For Sale

FOR SALE: OFFICE EQUIPMENT AT 50% DISCOUNT OR BEST OFFER: 4 examining tables, 1 Burdick EKG, 1 magnethern, 1 autoclave, 1 office table, 3 large filing cabinets. Call Mrs. Lleva, (608)323-3712 or (715)743-2324.

12/94

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Wausau Primary Connection Health Care, Inc. 645

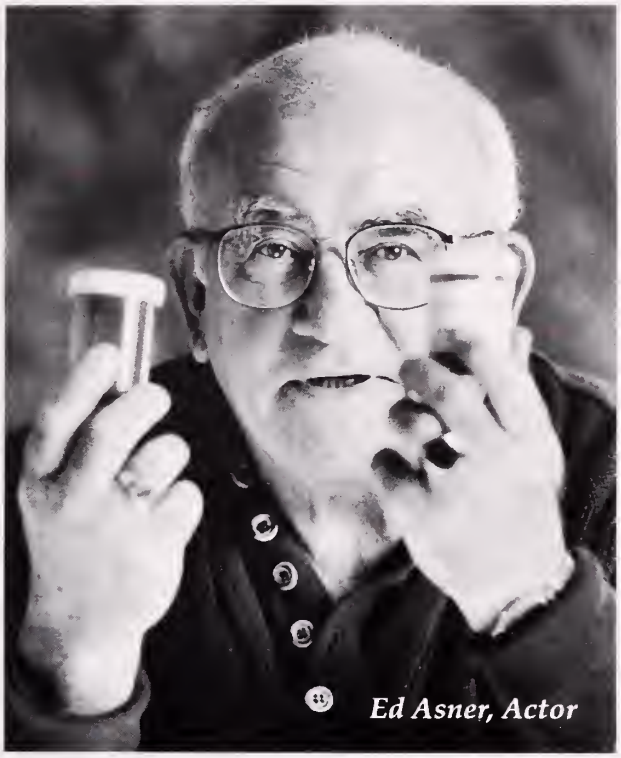
THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association.*

Attention: Physicians



Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

The next time you prescribe a medicine, ask your patients:

"What other prescription and nonprescription medicines are you taking?"

YES! Please send me free information to use when talking with my patients about their multiple medicine use.

Name

Address

City State Zipcode

Mail to:
NCPIE
666 Eleventh Street, NW
Suite 810
Washington, DC 20001

OR FAX: (202)638-0773

A public service message from the National Council on Patient Information and Education (NCPIE) and the U.S. Administration on Aging

HAPPY HOLIDAYS!

PIC Wisconsin wishes you a joyous holiday season, and a healthy and prosperous New Year.

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